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POLIOMYELITIS AND POLIOENCEPHALITIS.

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A GROUP of seven cases of affections of the central nervous system was admitted to the Belgrave Hospital for Children within less than a month from different parishes in the neighbourhood. They presented points of interest to the practitioner as regards diagnosis and prognosis, and to the pathologist and epidemiologist as regards the close connection between poliomyelitis and encephalitis, and the possibility of an endemic outbreak of these diseases. The dates given with each case indicate the duration of the period in hospital.

(1) ACUTE ANTERIOR POLIOMYELITIS.

Female, aged 3 years 5 months, Clapham; September the 9th to October the 8th.—The child was taken suddenly ill on September the 2nd with fever and delirium at night. There was no vomiting and the bowels acted normally. Loss of power in the legs was noted on September the 6th, and she complained of pain all over

and in the ear. Her family history was unimportant, and her only illness had been measles two years ago.

On admission.—No fever; cries out with pain on passive movement of the limbs and on being lifted up; appears unable to move the right arm and left leg; knee-jerks absent; abdominal reflexes present; bilateral otorrhœa. The otorrhœa ceased on September the 10th, but recurred from September the 22nd to the 24th. The right arm rapidly recovered, and there was slow but steady improvement in the left leg. Although the muscles were flabby there was no deformity or definite wasting on her discharge from hospital.

(2) Acute Anterior Poliomyelitis.

Male, age 4½ years, Peckham; September the 9th to the 24th.—Sudden onset on September the 3rd, with several attacks of vomiting, headache and fever. Weakness in both legs, without pain, was noticed by the mother on September the 5th. The family history was unimportant. There was a past history of measles two years and sore throat two months ago.

On admission.—Complained of pain in left ankle; left lower limb very flaccid, and tender to the touch and on passive movement; deficient abdominal reflex on the left side and absence of the left knee-jerk; plantar reflexes normal. Pain in the left leg ceased by September the 11th. One week later the movements were much improved; the left knee-jerk was present but sluggish, and the abdominal reflexes were brisk. Four days later the knee-jerks were brisk, but there was still a little paresis of the left leg. Recovery was apparently complete.

(3) Polioencephalitis.

Male, aged 7 years 4 months, Tooting; September the 9th to October the 1st.—Sudden onset on September the 7th with frontal headache and tiredness; vomiting at frequent intervals of about an hour up to next evening; bowels open on September the 8th; fainted twice in the Out-Patient Department on the 9th. Past history of measles and pertussis at age four years, varicella and mumps at five years, and two attacks of influenza a year ago. Admitted as a case of meningitis. Good nutrition, very drowsy, complaining of pain in the mid-dorsal region and the occiput. On examination: Temperature 98·6° F.; pulse 80 and regular; respirations 24; *tache cérébrale;* abdominal reflexes present, knee-jerks

doubtful; Kernig's sign present; no ptosis, squint or fundal change.

The temperature rose to 100·8° F. at night and 102° F. next morning, falling gradually to normal on September the 12th. On September the 10th he looked much brighter, complained of frontal and occipital headache, and presented the same physical signs except the backache. The cerebro-spinal fluid was clear, under great pressure, and did not clot. On September the 15th he was quite bright, free from headache, and had a good appetite and normal pulse, but Kernig's sign was still present, and he was costive. Two days later he was again very drowsy; temperature 100° F.; pulse 76; occipital headache, *tache cérébrale*, Kernig's sign and sluggish abdominal reflexes. The cerebro-spinal fluid was clear, showing marked lymphocytosis, few polymorphs, and no organisms. Next day and subsequently he was free from fever, recovering rapidly, and gaining over 2 lb. in weight in a week. Kernig's sign was still present on September the 25th.

The diagnosis in this case was peculiarly difficult. It rested between tuberculous meningitis, ependymitis, serous meningitis, encephalitis, and a mild type of basal meningitis. There was never any rigidity of the neck muscles, ocular signs, or turbidity of the cerebro-spinal fluid. On the whole I think it must be regarded as a case of encephalitis with considerable effusion of cerebro-spinal fluid. Recovery was complete.

(4) Polioencephalitis: Lethargic Type.

Male, aged 6 years 1 month, Streatham; September the 10th to October the 1st.—Onset on September the 6th with drowsiness and headache, and drooping of the eyelids during the day; no nausea, vomiting or fever.

On admission.—Good nutrition; normal temperature; pulse 80; respirations 24; staggering a little on walking, ascribed to weakness of the legs, but more probably due to lack of control; exaggerated abdominal reflexes and active knee-jerks, especially on right side. Voice shrill and said to have altered. Bilateral ptosis, with sluggish movements of the eyes but no squint, nystagmus or hippus; normal pupils and fundi. Cerebro-spinal fluid clear, not under pressure, non-coagulating, and free from micro-organisms and cellular elements. On September the 11th he presented, in addition to his other physical signs, some spasticity of the right leg and pain in the hip on passive movement; pain all along the leg on attempting to put it to the ground; exaggeration of the right knee-jerk. On September

the 15th there was no pain and less spasticity; still ptosis, slight internal left squint; exaggerated abdominal and patellar reflexes; constipation; pulse 60.

September the 18th: Free from drowsiness, pain and spasticity; very bright, and walks without difficulty; abdominal and patellar reflexes active and equal on both sides; slight squint and less ptosis. Recovery was uninterrupted, but there was still a little ptosis when he was discharged and on October the 7th. The voice had become normal. Throughout the illness he had no fever, and no Kernig's or Babinski's sign, and he gained 3 lb. 6 oz. in weight from September the 11th to the 29th.

(5) Polioencephalitis.

Female, aged 15 months, Battersea; October the 2nd to the 16th. —A history, somewhat vague, of an injury to the left side of the head from a fall on September the 23rd. Vomiting, fever and drowsiness next day; bowels open, but ol. ricini was given and acted well. Child improved and remained well until October the 1st, when she vomited several times, and during the next night passed a loose, watery stool, and became feverish and drowsy. The mother has pulmonary tuberculosis and four other children living, one of which, aged 13 years, attends a tuberculosis dispensary; one child died from convulsions. The patient had had no previous illness, and was admitted in a state of drowsiness with vomiting as probably tuberculous meningitis. The child was well nourished, weighing 19 lb. on October the 6th; still drowsy, but taking fairly well and free from vomiting. On October the 9th she had gained 6 oz. Next day she had projectile vomiting after almost every feed; a peculiar look about the eyes as if she had headache; diminished or absent abdominal and patellar reflexes (obtained on the left side on admission). There was no more vomiting after the 10th, and drowsiness passed off next day. On October the 16th her general condition was excellent, with no sign of palsy, but both the superficial and deep reflexes were absent. She had gained a further 29 oz. in weight. There was no fever throughout.

At first the appearance of the child and the family history suggested a diagnosis of tuberculous meningitis of the somnolent type, but she did not seem ill, and there were no definite signs of meningitis. Possibly the illness was secondary to "bruising" of the brain, but there was no evidence that the fall was a bad one and no indication of concussion the same day. Another possible diagnosis is a mild

poliomyelitis, because of the alteration in the reflexes. If so, I think it must have been combined with some encephalitis, in view of the drowsiness and vomiting. As the child did not seem seriously ill and had no bulging fontanelle, the cerebro-spinal fluid was not examined.

(6) Encephalitis.

Male, aged 13 months, Lewisham; October the 3rd to the 16th.—Tenth child; none ill or dead. Two weeks ago he had a fit, since then athetoid movements of the upper limbs and stiffness of all the limbs; another fit a week ago.

On admission.—Difficulty in swallowing, but takes food; saliva dribbles from the mouth; marked athetosis and rigidity of the upper limbs, aggravated by excitement; the arms adducted, forearms flexed, wrists and fingers flexed; lower limbs presenting a condition like that of spastic diplegia; exaggerated knee-jerks and ankle clonus. The athetosis persisted at first, though less markedly during sleep, ceasing during sleep on the 9th. On October the 8th he weighed 13 lb. 12 oz.—a gain of 2 oz.; he then started vomiting, projectile in type, and on October the 13th he had lost 18½ oz. Examination on this date showed marked spasticity but less athetosis, rather more in the left than the right arm. There was no crying and no appearance of mental deficiency. Head 18½ in., small fontanelle, twelve teeth, slight rickets. A dusky patch, ? choroiditis, in lower inner quadrant of right fundus; normal left fundus. Vomiting continued, appetite failed, and death resulted from asthenia. The temperature remained at about 96° F. from the day of admission up to the 13th, after which it rose gradually to normal on the day of death. There were no more fits.

Post-mortem examination revealed a very considerable degree of congestion of the meningeal veins, dilatation of the blood-vessels in the cortex of the brain and patchy areas of softening. Lumbar puncture during life failed to obtain any cerebrospinal fluid for examination. This was unfortunate, as it would have been interesting to compare its characters with that obtained in some of the other cases. It was very remarkable that there were no further convulsions considering the state of the brain as seen after death. There was no bulging fontanelle during life.

(7) Basal Meningitis.

Female, aged 6 years 9 months, South Lambeth; September the 22nd to October the 14th.—Sudden onset with nausea but no

vomiting on September the 19th; anorexia, constipation and fever. Next day the child vomited several times and complained of pain in the back of the head and neck; she was unable to swallow, and milk regurgitated through the nose. Her family and past history were unimportant.

On admission.—Very drowsy; pain in back of head and neck, with some rigidity of the neck and retraction of the head. No fever; pulse, 112; respirations, 36. Eyes normal; tongue much coated; abdomen retracted; marked *tache cérébrale;* abdominal reflexes present; Brudzinski's neck sign and Kernig's sign present; active knee-jerks. Cerebrospinal fluid clear, under pressure, free from organisms, and showed lymphocytosis.

She remained in practically the same condition for several days.

September the 29th: No head-retraction, but passive movement still painful; able to swallow and has less regurgitation through the nose. The other physical signs were unaltered. Regurgitation ceased next day. On October the 6th *tache cérébrale,* Kernig's and Brudzinski's signs were still present. A week later she had recovered, but there was a slight nasal twang in her voice, said not to have existed previous to her illness. The-knee jerks were exaggerated.

Temperature 99·6° F. on admission and practically normal afterwards. The pulse-rate was almost always 112–124, occasionally 88–100, and at first there was much constipation.

The case was remarkably like one of tuberculosis meningitis in its symptomatology and the characters of the cerebrospinal fluid, but the pulse was not at all suggestive of this diagnosis. There was no headache or indication of cerebral pressure. The regurgitation and nasal twang in the voice raised the question of diphtheria, but there was nothing confirmatory of such an infection. I think the diagnosis is reduced to that of some mild type of basal meningitis, in spite of the characters of the cerebrospinal fluid.

The difficulties in the way of accurate diagnosis of cases of poliomyelitis, various types of encephalitis and meningitis are very great even in hospital practice, where the patients are generally admitted after some days' illness and are under careful observation and examination afterwards. In private practice they may be insuperable in early stages. Moreover, many cases cannot be definitely placed in any one group, the affection is not always limited to the brain or the cord or the meninges, and consequently symptoms overlap and are at times mixed up in such a way as to

cause confusion. Cases of poliomyelitis are sent to hospital as meningitis and *vicè versâ*. The notes of a case sent up as ? meningitis may be added as a further illustration of the difficulties.

Male, aged 3½ years, July the 5th to the 30th.—On June the 27th he fell flat on his back from a cart. On June the 29th he went for a drive in an open motor car, and at night he was seized with vomiting, diarrhœa and fever. Next day he had pain all over and "could not see properly"; vomiting, constipation and difficulty in micturition. On July the 2nd he complained of headache, and at night, two days later, he had an attack of general rigidity for a few minutes. Examination on July the 5th showed a normal temperature, slight head-retraction, *tache cérébrale*, normal abdominal reflexes, absent knee-jerks, paralysis of the lower limbs and paresis of the right arm, and loss of sensation to touch and pain in the lower limbs.

Possible diagnoses in the early stages were hæmatomyelia due to injury, cerebrospinal fever, encephalitis or some type of meningitis. It was perfectly clear, when I saw the boy on July the 5th, that the condition was due to acute anterior poliomyelitis, with extension to the posterior nerve-roots of the spinal cord. And there seems little doubt that the affection was not limited to these regions in the earlier stages, but had also to some extent involved the brain. The cerebrospinal fluid was examined next day and was found normal and not under pressure. Sensation returned in the lower limbs in five days. The right arm recovered, but there was not much improvement in the legs in three weeks.

The chief factors of value in differential diagnosis are the reflexes, taken in conjunction with other symptoms. A *tache cérébrale* is in favour of a diagnosis of cerebral involvement. Fever was absent in these cases almost entirely after admission to hospital, and not much information could be obtained of positive value from the temperature charts. Examination of the cerebrospinal fluid affords valuable assistance. On the other hand it is sometimes not obtained on lumbar puncture, and occasionally the degree of illness hardly warrants the exploration.

SEQUEL OF THE CASE OF LIPODYSTROPHIA PROGRESSIVA SHOWN ON JANUARY THE 24TH, 1919.*

By F. Parkes Weber, M.D., and T. H. Gunewardene, M.R.C.S.

With a Microscopical Report by H. M. Turnbull, M.D.,

Director of the Pathological Institute of the London Hospital.

The girl, aged 13 years, was re-admitted to the East London Hospital for Children on May the 19th, 1919, with purulent otorrhœa on the left side (of one month's duration) and swelling in the left mastoid region (of six days' duration). A left mastoid operation was performed on May the 20th, 1919. Soon afterwards there was a septic (pyæmic) type of pyrexia, which lasted till the patient's death (from pyæmia) on September the 8th, 1919.

Necropsy (on September the 9th, 1919).—The body was altogether much wasted, but by naked-eye examination fat was practically completely absent from the subcutaneous tissue of the upper part of the body (above the pelvis). A moderate amount of fat was present in the gluteal regions, orbits, omentum, about the kidneys, heart and pericardium, and under the serous membranes. Had the child died, not from chronic pyæmia, but from some disease not associated with extreme wasting, there would doubtless have been much more fat left in the regions unaffected by the lipodystrophia. There was no evidence of any tuberculosis anywhere. Excepting what was connected with a left empyema and the pyæmia (including parenchymatous nephritis and large septic liver and spleen) and the lipodystrophia, there was nothing obviously abnormal to naked-eye examination. The thyroid gland was relatively rather large, and by macroscopic and microscopic examination was found to be very rich in colloid material. The thymus gland was represented by a scanty remnant. The brain did not appear in any way diseased.

Microscopic examination of one ovary, the pituitary gland, and both suprarenal glands showed nothing special. A piece of the anterior abdominal wall and a piece of the hairy scalp from the occipital region were found microscopically to contain no fat-vesicles in the subcutaneous tissue (special stains for fat were not employed), thus confirming the naked-eye appearances mentioned above, and likewise confirming results of "biopsy" examina-

* 'Proc. Roy. Soc. Med.,' Section for the Study of Disease in Children, 1919, xii, p. 13. (British Journal of Children's Diseases, 1919, xvi, p. 89.) The present account (sequel) was read before the same Section on October the 24th, 1919.

tions made in previously published typical cases of lipodystrophia progressiva.

The fat-atrophy in the parts specially affected in cases of lipodystrophia progressiva seems to be more extreme than that met with in post-mortem examinations on even the most wasted subjects of chronic pulmonary tuberculosis. Nevertheless, persons with lipodystrophia progressiva appear, as a rule, to enjoy good general health, and their average capacity for work is probably quite up to the normal for ordinary persons of the same age as themselves. Their facial appearance is the chief source of trouble, because employers think they must be suffering from "consumption," and this may prevent them from obtaining work; fellow-clerks and others may, for the same reason, be frightened to work in the same room with them. Their wasted, cadaverous aspect may be seriously distressing to them, especially in the case of females, and still more so if they have to earn their livelihood by dancing, etc., on the stage.

When all the fat has disappeared from the parts of the body affected in lipodystrophia progressiva the disease naturally comes to an end, and therefore, strictly speaking, can no longer be correctly termed *progressive*. As far as we know, in cases of lipodystrophia progressiva, the fat, when once atrophied, never returns, but, as the patient grows older, the subcutaneous connective tissue probably increases somewhat, and the emaciated face no longer arrests attention to the same degree as it did. Moreover, thinness of the face is naturally less noticeable in elderly persons.

The present seems to be the first published *post-mortem examination* on a case of lipodystrophia progressiva. We therefore thought that as much critical information as possible ought to be obtained in regard to the microscopical appearances. Dr. H. M. Turnbull (of the Pathological Institute of the London Hospital), to whom our best thanks are due, has very kindly examined the sections, and has furnished us with the following report.

Microscopical Report by Dr. H. M. Turnbull.

The sections are stained with hæmatoxylin and eosin.

(1) *Scalp.*—The skin is cut obliquely. Consequently, the roots of the hairs are cut transversely. In the deeper part of the section there are transverse sections of a few hair-bulbs, with their papillæ, and several roots cut immediately above the level of their papillæ. It is clear, therefore, that the section includes a depth of scalp at

which, under normal conditions, subcutaneous fatty tissue would be present. Indeed, beneath the level of the hair papillæ, the greater part of the section includes a layer of horizontal fibres and vessels. There can be little doubt that this layer represents the aponeurosis which normally lies beneath the subcutaneous fatty tissue.

External to the hair-follicles in the deeper part of the section there are a few small areas which may contain small fat-cells. Apart from these small doubtful areas there is no evidence of fatty tissue. The interstitial tissue of the scalp is much denser than normally. The arrangement of the fibrous bundles appears, however, to be normal, so that there is no evidence of inflammatory fibrosis. The density appears to be due simply to the absence of fatty tissue.

(2) *Abdominal wall.*—The section at one small spot passes right through the abdominal wall, from the epidermis to the parietal serosa. In the remainder of the section the deep aponeurosis and peritoneum are absent. Sections of similar portions from normal abdominal walls of adult females show a deep layer of subcutaneous fatty tissue between the dermis and the muscle, a variable amount of fatty tissue in the intra-muscular septa, fatty tissue between the muscle and deep aponeurosis, and lobules of fatty tissue between this deep aponeurosis and the fibrous peritoneum.

In none of these positions can I detect fat-cells. Owing to the method of preparation of the section this observation does not exclude the presence of such cells, but it can be said that, if any fatty tissue is present, it must be astonishingly scanty.

(3) *Thyroid gland.*—The section appears to include a complete transverse section of a lateral lobe. There is an unusual amount of colloid in the acini throughout the section. The excess of colloid is associated in some acini with a slight desquamation of proliferated epithelial cells. The condition of the acini suggests that the gland was in a state of moderate colloidal over-activity. At the same time, as far as can be judged without a special stain, the interstitial tissue is more abundant and denser than in control specimens showing colloidal hypertrophy in children of the same age, and, indeed, more abundant and denser than in the normal thyroid.

The appearances of the whole section suggest that a moderate degree of over-secretion of colloid was associated with a slight fibrosis and actual diminution in size of the gland.

(4) *Both suprarenal glands* (*Sections A and B*).—Section A is taken from a portion of the gland peripheral to the medulla. Section B includes medulla.

The cortical cells are small. Their cytoplasm is deeply stained and displays little vesiculation. I conclude from this that the zona glomerulosa and zona fasciculata contain less lipoid than is usually present at the age of thirteen years.

It is unfortunate that very little retroperitoneal tissue is included in the sections. There is, however, sufficient to show that fatty tissue is present (Section A).

(5) *Pituitary body.*—The section has been made transversely through the anterior lobe, a small part of the stalk being included. Since our routine procedure is to make a sagittal section through the centre of the gland I am unable to make use of controls. Further, the method of staining has not differentiated clearly the chromophobe cells from the chromophil, and the cyanophil cells from the eosinophil.

I can only say, therefore, that several acini enclose a central mass of secretion, and that I detect no gross abnormality in the gland.

(6) *Ovary.*—I can detect no abnormality in the ovary. It contains numerous primary follicles lined by a single row of flattened or of cubical epithelial cells, a follicle lined by stratified epithelium and containing a little liquor, and one fully-developed Graafian follicle.

Conclusion.

In the sections of the scalp and abdominal wall the only evidence detected of fatty tissue was the presence in the scalp of a few small areas which may have been occupied by fat-cells. In the absence of special stains it is not possible to exclude the presence of some fat-cells, but the sections suffice to show that fatty tissue is almost completely, if not completely, absent.

One of the sections of the suprarenal bodies includes a little of the surrounding retroperitoneal tissue. Definite fatty tissue is present in this.

In no section are there lobules of embryonic fatty tissue such as are found in the fœtus, and in infants during the first and even second year of life.

I can detect no abnormality in the ovary. If I had sections of the anterior lobe of the pituitary gland stained in a manner to differentiate the cells, I might record the relative number of the different kinds of cells, but I could not attempt to interpret their significance without making a special investigation into the changes found in health and disease in the anterior lobe of girls of thirteen years of age. In the suprarenal bodies there appears to be less lipoid

than usual in the cortex. This difference from available controls is so slight that it would be very dangerous to consider it of special significance. It would appear to fall within the limits of normal physiological variation. Further, the effect of the infection which caused death cannot be excluded.

In the thyroid gland there is an excess of secretion of colloid. An excess of this degree is often found at post-mortem examinations. It falls far below that which frequently occurs at puberty. Little significance can be attached, therefore, to this excess of colloid, if it is the only unusual feature. But the excess of colloid appears to be associated with fibrosis. Without a special stain, however, I cannot say definitely that fibrosis is present. The naked-eye examination and the measurements and weight of the gland should give exact information on this point. If the excess of colloid was such as occurs physiologically, especially at puberty, the gland would be correspondingly enlarged, and the interstitial tissue would appear rarefied rather than thickened. If the colloidal over-activity in this case was associated with fibrosis and with no enlargement, or with actual diminution in size of the gland, then a pathological condition was present, and not a phase of normal activity. It would be reasonable to consider that such a pathological condition of the thyroid was connected with the abnormality in the subcutaneous fat.

SCHOOL DENTAL CLINICS AND THEIR MANAGEMENT.

By C. Edward Wallis, L.D.S.Eng., M.R.S.C., L.R.C.P.,

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For the purposes of this paper let us assume that the education authority of some particular town or city has agreed to the establishment of a "scheme" of school dental treatment, and that the medical officer of health and perhaps the dental surgeons of the city have been invited to co-operate and advise as to the best means of setting about it.

It will be noticed that the word "scheme" is used, and this is said advisedly. It is not infrequently thought that *all* that is necessary is to provide a dental clinic and that the school medical inspections alone will be sufficient to keep it occupied.

This experience shows to be a complete fallacy, as the writer was able to demonstrate from some special dental inspections in the East End of London, *immediately following* the official school medical inspections.

The result, of course, as dental surgeons will see at once, was a foregone conclusion : the only cases notified for dental treatment by the school doctors were the glaring cases of oral sepsis and carious teeth usually beyond all hope of conservative treatment.

Having no special training in the detection of caries the school *doctors* had naturally failed to detect the small, pinhole and interstitial cavities, with the result that large numbers of the children were passed by as dentally healthy who were shown next day with a probe and mirror to be honeycombed with undiscovered caries.

It is therefore plain that if we are to save teeth, the children must be properly inspected by a dental surgeon with a view to detecting and treating caries at its earliest onset, and not when the crowns of the teeth have disappeared.

School Dental Inspection.

Let us now discuss the question of school dental inspection as to *how* and *where* it is to be carried out.

The cardinal principle in school dentistry is that prevention and treatment should be developed side by side ; thus the dental inspection sessions should be utilised, not only for examining the teeth, but also for instructing and generally interesting children, parents and even teachers in their care and value.

In London the actual dental inspections take place in the schools themselves, from 100 to 150 children having their teeth thoroughly inspected with a probe and mirror by the inspecting dentist at each periodical inspection session.

The parents are not invited to be present at the actual inspections as it was found that their presence delayed the work, but instead they are invited to attend for the last half-hour of each dental inspection, during which the inspecting dentist gives a short address—the word " lecture " is carefully avoided—on the importance of taking care of their children's teeth, with special emphasis on *oral sepsis* as a cause of ill-health ; this is followed by a personal talk with such parents as wish to ask questions about their children's teeth.

During the war, owing to a large number of mothers being

engaged in munition work, the attendance of parents considerably fell off, so that led to the development of the plan of addressing in *addition* the elder children who are assembled for the purpose.

Certain school teachers are usually present on these occasions, and can and do render the greatest assistance in obtaining the consent of parents unwilling to consent to treatment for their children.

As a class elementary school teachers are admirable people, full of interest in their children and very appreciative when an inspecting dentist goes out of his way to explain points of dental interest, such as the seriousness of oral sepsis, the causes of irregularities, the absence of upper lateral incisors, the teeth of congenital syphilis and so forth.

In this way, if a school dental inspector does his work in a deliberate, unhurried way and makes the inspection of interest to those around him he will find that their co-operation will follow as a matter of course, whereas the opposite will obtain if the inspections appear to be perfunctory and to be got over as quickly as possible.

As each child passes the dentist the teeth are inspected with a probe and mirror, and what is required is recorded in an appropriate place on the child's *medical* card by an assistant organiser whose business is to arrange in advance for the proper carrying out of these inspections.

No *dental* charting is done at the actual dental inspections as experience shows that it is a waste of time; all that is required is to record whether or not the child needs dental treatment, urgent cases being specially underlined in order to receive earlier attention.

The assistant organiser, already referred to, belongs to a special department of the London County Council organisation concerned with work of this kind and brings with her the necessary parents' consent and appointment cards, so that those present may sign them there and then, while if absent, it is the business of the organizer or a member of the School Care Committee to obtain the necessary signature of consent to treatment.

The organiser also arranges that schools and clinics are provided with special tooth-brushes, tooth-paste and tablets of permanganate of potash which are sold to the parents of children at cost price.

Age for Commencing Dental Inspection.

The official Board of Education age for commencing the inspection of school children's teeth is from 6 to 8—that is to say, that when a

new centre or clinic is first opened the children inspected are of the ages 6, 7 and 8 years.

At the second annual dental inspection the children inspected are aged 6, 7, 8 and 9.

At the third completed dental inspection the children are of the ages 6, 7, 8, 9 and 10, and so on until every age-group is included.

All these cases are examined and re-examined as far as possible every twelve to fifteen months in each dental centre area.

Besides the children who attend the centres as the result of these routine dental inspections a certain number of children, not yet inspected by the dentists and sent by the school doctors, attend for treatment; these are described as sporadic or over-age cases.

The opinion of the writer is that the age-group selected for inspection and treatment of the first group, namely 6 to 8, is really too late, and that much caries may already exist which should have been treated at an earlier age; this opinion is gaining ground, and in all probability an alteration will be made in this respect in the near future.

Though in London "infants" so-called are not dentally inspected as part of the routine, a number of them do in fact attend the centres for treatment, either on the advice of the medical inspectors or at the request of the parents themselves.

Unfortunately attendance at infants' schools is not compulsory, and consequently it is only a small proportion who *do* attend, and of that proportion still less obtain dental treatment (because not dentally inspected).

It would be well to state here that each school dental "centre" or clinic should have allotted to it what one might describe as a "sphere of influence"—that is, a number of schools for the dental inspection and treatment of which it is responsible.

Thus, as it were, an irregular circle is drawn having the clinic for its centre, and including the number of schools of various sizes within its area which will enable the children to be dentally inspected every twelve to fifteen months.

Let us now come to the school dental clinic itself: What accommodation should it have and where should the premises be located?

It is most important that a clinic should be readily accessible, and, if possible, on a 'bus or tram route; the latter may be found specially suitable when extractions are going on as they can be timed to coincide with the passing of the tram, for obvious reasons!

The minimum accommodation required is three rooms, namely, a surgery with a recovery-room immediately adjacent and a waiting-

room as far away as possible—that is to say, out of earshot of the surgery—and the rooms should be so arranged that the children leaving the clinic shall not be seen by those awaiting treatment.

It is usually quite unnecessary to erect a special building for the purpose, as a large house with good rooms on the ground and first floor answers admirably.

With regard to the various types of premises, perhaps it will be interesting to know that of the forty-seven London clinics, four were orginally public-houses; twenty-one are adapted private houses; six were shops; others are located in public institutions of various kinds, such as dispensaries, hospitals and so forth. None of these are on school premises.

Most of the London clinics are used for other forms of treatment in addition to dentistry, and thus under the same roof we may have treatment for eyes, throats, ears, X-ray treatment for ringworm, and what is known as minor ailment treatment; usually only three or four of these branches of treatment are dealt with under one roof, but we have treatment centres in which all these are included.

It will at once be seen how beneficial it is that a child should have all these varieties of treatment available when required.

The dental surgery is not used for these ulterior purposes except in one or two instances, other rooms being set aside for what is required.

As regards the dental surgery itself, the writer's experience is that it should not be too small, as a small room on anæsthetic days becomes unbearable when the dentist, the anæthetist, the patient, and perhaps two nurses may all have to be accommodated at the same time.

The surgery should obviously face north or north-east—a surgery with a south aspect and a great pressure of work may become intolerable in the summer-time; it is only reasonable that a school dentist should be allowed to work under ordinary conditions of comfort as regards light and temperature.

In all cases hot and cold water should be fitted, and, as will be seen, a lavatory basin can quite well be replaced by an inexpensive sink with rose douches to the taps, so that the dentist can wash his hands in running water, and the sink at the same time be available for cleaning-up purposes.

In houses in which a hot water supply is not fitted the case can be met by installing a miniature geyser over the sink, which answers the purpose quite well, and is much better than a coil heated by gas.

With regard to the floor covering, linoleum or cork carpet answers

all requirements, and here experience suggests that the plan of selecting a uniform colour, whether green or brown, is not wise, as it shows every footmark, and after half an hour looks infinitely worse than does a Turkey-carpet pattern, which shows no marks at all.

Let us pass now to the subject of equipment; originally the sum of £50 was found, with economy, to be sufficient for the chair, foot-engine and instruments, but by stages during the war this grant has been increased to £75, in which is included the cost of the anæsthetic apparatus.

For the instrumental equipment in London there is a standard list, but the dentist is allowed to exercise his choice in the selection of the smaller instruments provided he does not select types unusable by a possible colleague or successor.

As regards the anæsthetics used, twenty-five centres habitually use ethyl chloride, while the remainder make use of nitrous oxide; thus during 1918, 14,000 children in London received nitrous oxide and nearly the same number received ethyl chloride.

One may perhaps here say that in the hands of a capable anæsthetist, experienced in its use, ethyl chloride is invaluable, as it enables all cases to be completed at one sitting and thus saves reappointments for extraction purposes. The only drawback is the somewhat more protracted period of recovery and the tendency to sickness in some cases, though this may be greatly minimised by proper preparation beforehand.

The scope of work at a dental clinic should involve the general principle of the greatest good of the greatest number—that is to say, a clinic dentist should so apportion his time that each child may receive the necessary treatment; cases have been known in which an undue proportion of time has been spent on one or two cases, with the result that the remaining children were sent away with little or nothing done.

The number of children seen at a London clinic at each session of two and a-half hours is estimated at roughly eight to ten new cases and such old cases as may attend.

Proportion of Anæsthetic Sessions.

The proportion of anæsthetic to ordinary treatment sessions was originally 1 in 9, that is to say, once in each fortnight; as this number was found in many cases to be insufficient a credit of extra anæsthetic session was allowed to each clinic to be drawn upon as required.

It is, however, found that as the older children now attend for

treatment the number of necessary routine anæsthetic sessions may reach two in each week for a whole-time clinic.

Staff of a Clinic.

The success or failure of a particular clinic is largely dependent upon the personality of the dentist in charge, though it is often thought that the mere possession of a dental diploma is sufficient evidence of suitability for the post of a school clinic dentist. Experience does not support that opinion, as much tact and diplomacy is required in addition to operative ability in order to manage children and parents, particularly in these undisciplined and Bolshevistic days.

The type of dentist most suitable for school-clinic work is one who has had experience of private practice, the art of managing children and parents, and the habit of working against time.

He should be possessed of some teaching capacity in order to explain to parents the treatment required in simple, everyday language; as has already been said, school dental treatment should be preventive as well as curative, and a few words to parents may do much to excite their interest and support and thereby spread abroad the importance of dental hygiene and its relation to health.

Part-Time or Whole-Time Dentists.

Speaking *broadly*, part-time, older school dentists are more satisfactory than whole-time, recently qualified young ones; it is the writer's experience that they do their work better, that their proportionate output of work is much greater from having acquired the art of working quickly, and that they obtain much more readily the ear and attention of school medical officers and teachers.

A common complaint of whole-time, recently qualified school-dentists in country towns is that they are treated by the school medical officer or medical officer of health as of no account; this is probably due to their lack of age and experience, added to which their organising and advisory capacity is for the same reason frequently conspicuous by its absence.

The younger *whole-time* school dentist usually, after a year or so, realises that he is doing himself no good, that he is gaining no experience to fit him for private practice, and steadily losing what he knew of prosthetic dentistry when he left the hospital.

Again, whole-time dentists are to an education authority an expensive luxury as they seldom stay more than two or three years

at the outside, and when another is appointed he expects a batch of new instruments, is unknown to parents and teachers, and again breaks the continuity and interest of his relations with the children and parents. A dentist already in practice is frequently *glad* of a certain income of £100 to £250 a year towards his house-rent, and so is enabled to develop his connection while doing a certain amount of part-time public dental work.

It should be here explained that though the preceding is the writer's general opinion, he is aware of a few whole-time dentists who would be an acquisition anywhere: in *each case*, however, they are men who have retired from practice in the prime of life, and have entered upon school dentistry with the priceless asset of experience in the management of patients.

In country districts, as, for example, in dealing with the school-dentistry of a county, the difficulty becomes very great, as naturally dentists in practice are unable to give up the necessary time, and consequently there is practically no alternative but a whole-time appointment.

It would appear that the only way to obtain really capable men for such country posts is to offer first of all a good salary, and also the prospect of some well-paid dental administrative post in later life, when the provision of public dental service increases to the extent *it must*, under the Ministry of Health with its vast possibilities.

Anæsthetists.

Let us next consider the question of the selection of anæsthetists for dental clinic work. Here again it is absolutely necessary to have men who really understand the art of giving either nitrous oxide or ethyl chloride for dental purposes.

Many cases of medical men giving anæsthetics in dental clinics have been known who actually knew nothing whatever about it, and, worst of all, seemed incapable of learning.

It should surely be impressed upon the councils that make these appointments that the mere possession of a *medical* degree or diploma is no evidence of ability as an anæsthetist, and that definite evidence should be produced of experience of the administration of anæsthetics for dental purposes.

Dental Clinic Nurses.

It is essential that a nurse should be provided to assist the dentist at a clinic, and one should be selected who is not only accustomed

to the management of children and parents, but who is also willing to help in the mixing of stoppings, sterilising and custody of instruments, and so forth; on anæsthetic days the presence of an extra nurse is necessary to take charge of the recovery room.

An attendant or caretaker who can keep troublesome children in order in the waiting-room is also essential, and who, when the clinic is closed, should be responsible for the general cleaning and so forth.

Supervision of Work.

Where there are several clinics in a town or district, it is essential that a *supervisory dentist* should visit the clinics periodically, and also see to it that the work of the clinics is properly co-ordinated; the plan of leaving clinics to themselves and merely counting up the number of extractions and stoppings is by no means a satisfactory way of assuring that good work is being done.

Let us now draw attention to a valuable development of school dentistry, which has been initiated by Fones, Director of School-Clinics in Hartford, Connecticut.

It consists of the employment of trained women known as dental hygienists, who pay routine visits from school to school in order to carry out the surface treatment of children's teeth.

Fones declares that if teeth are thoroughly and skilfully cleaned at suitable intervals 80 to 90 per cent. of dental caries can be prevented—in other words it is what the Americans call prophylaxis applied to school children.

No operative work of any kind is done by these women dental-hygienists beyond the surface "toiletting" of the teeth of the school children.

New York has now started a similar service on the same lines, and, as Fones has had this dental hygienist work recorded on cinema films, before long we may be able to show what is actually done *on the screen.*

Infants' and Mothers' Welfare Centres.

Attention is here drawn to the advisability of the development and co-ordination of mothers' and infants' welfare centres in connection with school clinics for the dental treatment of expectant and nursing mothers and infants not yet attending infant and nursing schools.

It is quite possible to set aside *one or more afternoons* in each week

for this purpose, and experience shows that if properly worked they are of the greatest benefit, as we all know the teeth of expectant and nursing mothers of the poorer classes are beyond description and urgently calling for treatment if the children of the future are to have a fair start in life.

It is also possible to arrange for expectant and nursing mothers after treatment has been completed to be supplied with dentures on a system of payment by instalments.

Under the new Ministry of Health great development must undoubtedly take place in regard to the school-dental treatment of children, and it therefore behoves all interested in public work to gain a general knowledge of the experience already obtainable.

Royal Society of Medicine.

SECTION FOR THE STUDY OF DISEASE IN CHILDREN.

Friday, May the 23rd, 1919.

The President, Dr. J. Porter Parkinson, *in the Chair.*

Lymphangioma of the Tongue.—Mr. B. Whitchurch Howell.—The patient was a boy, aged 6 years, the only child. The birth was a natural one. There was no family or personal history of disease. He gave a negative Wassermann reaction. He had a congenital nævus of the lower lip, which involved the mucous membrane of the gum. This got fuller when the child cried, and bled occasionally. The swelling of the tongue was first noticed when the child was three years of age. It commenced on the posterior aspect, and had grown slowly forward. It was now stationary, vesicles continually broke down and ulcerated, causing pain, and on that account the boy bolted his food, which was always minced. He ate most things, and took a rather large amount of salt, of which he was fond, but avoided sauces. Occasionally the tongue was enlarged without apparent cause, and protruded from the mouth. It was then excessively painful, and was a source of anxiety to the patient and his parents. Salivation was excessive and articulation impaired. The tonsils were much hypertrophied, the submaxillary lymphatic glands were much enlarged, and the submental glands were palpable. This condition was extremely like those described by the late Sir Henry Butlin in his book on diseases of the tongue, and in St. Bartholomew's Hospital Museum there were several drawings and paintings showing this condition. Sir Henry Butlin used to remove a V-shaped portion of the tongue in these cases, but apparently surgery would not be of use in this patient, especially as Sir Henry Butlin said these cases were progressive.

Case for Diagnosis.—Dr. E. A. Cockayne.—The patient was a boy, aged 11 years. He had had influenza in December, 1918. He had never been well enough to go to school since, and had been languid and unwilling to play out of doors. A month ago he became very drowsy. His appetite was good and he had no vomiting. There was no family history of tuberculosis. The boy was wasted and looked delicate. There was slight jaundice, which had remained unchanged during the fortnight he had been under observation. The abdomen was prominent, especially in the upper part, and difficult to palpate. Both the right and left lobes of the liver were greatly enlarged; the edge of the right lobe could be felt some distance below the level of the umbilicus. The surface was smooth and the organ felt firm, but not extremely hard. The spleen was palpable and the splenic dulness was increased. There was no ascites, no tenderness, no abdominal pain. No enlarged glands could be felt anywhere. There were no enlarged veins over the abdomen and no spider nævi anywhere. There had been no hæmorrhages. The stools were normal in colour and consistency. Urine, dark in colour, contained a trace of bile, but no excess of urobilin. There was a trace of albumin. Red blood-cells, 6,100,000 per c.mm.; leucocytes, 6400 per cubic c.mm.; polymorphonuclear, 54 per cent.; mononuclear, 46 per cent.; Wassermann reaction, negative; evening pyrexia, 100° to 101° F. on most days. Dr. Cockayne thought the case was one of abdominal tuberculosis; the facies of the boy was not characteristic of cirrhosis of the liver: the liver was smooth, and did not feel so hard as was usual in that condition. The question of hæmolytic jaundice had suggested itself, but there was no definite bile in the urine, and only a trace of urobilin. The spleen was not as large as and the liver was larger than one would expect, and there was no anæmia, yet the child was ill. He did not think there would be such a degree of illness in an exacerbation of hæmolytic jaundice unless there was marked anæmia.

Abdominal Case for Diagnosis.—Dr. E. Pritchard.—The patient was a girl, aged 3¼ years. There was a history of tuberculosis in the family. Symptoms of abdominal pain commenced six months ago, and had continued on and off ever since. The pain usually came on immediately after food. There was much wasting, sweating at nights, and occasionally blood in the stools. The belly was doughy. On palpation a tumour could be felt extending across the abdomen just above the level of the navel, and below, in the position of the left kidney, there was a smooth, rounded tumour, dull to percussion and elastic to the touch. Dr. Pritchard thought that the case was one of abdominal tuberculosis. He had brought the case because of the presence of the tumour in the position of the left kidney. It was so smooth in contour that when he first palpated it he thought it was hydronephrosis, or a cystic tumour of some kind in the kidney region. It did not seem to accord with what he had previously met with—cases of abdominal tuberculosis with large deposits in the omentum. He brought the case in order to elicit the opinions of members as to whether the swelling was simply a loop of intestine entangled in the omentum which gave an impression of being cystic, or was really a tumour. Two skiagrams showed very large deposits, not only in that region, but also on the right side, which were so opaque that they might be calcified glands. Since showing the case the tumour had become resonant, confirming the view that it was an incarcerated loop of intestine.

Case of Joint Trouble.—Dr. C. A. King showed a boy, aged 7 years. She had first seen the boy in June, 1918, when he had an attack of erythema

nodosum, which quickly cleared up. He came back in the following December with a history of pain and swelling in the right knee of three weeks' duration. He also complained of pains in the hips and ankle-joints. There was considerable effusion into the right knee, but the other joints appeared normal. The heart was unaffected and no other signs of disease were detected. He ran a moderate temperature for a week, but the condition cleared up under salicylates. A week or two after discharge from hospital there was return of trouble in the knee-joint. X-ray examination showed effusion, but no other sign of disease. He had a Wassermann test done, and the reaction was strongly positive. He had been on anti-syphilitic treatment since. The fluid had subsided, but the condition of the knee had not cleared up so quickly as had been expected. The second attack had been practically apyrexial. The father, who was killed in France, was healthy; the mother had had rheumatic fever since, and there were four full-term children. There was no history of miscarriage.

Case of Syphilitic Bone Disease.—Dr. J. Porter Parkinson.—The patient, a girl, aged 12 years, with a healthy family and personal history, giving no suggestion of syphilis, two months ago had pain and swelling in the right under eyelid; a week later she had pain and swelling in the right ankle, followed by similar symptoms in the left elbow. The pain became less, but the swelling persisted, and she was brought to hospital. She was a well-nourished, healthy-looking girl, with no signs of syphilis. The incisor teeth were normally shaped. The leg above the right ankle was swollen, this being due evidently to enlargement of the lower end of the tibia; the movements of the ankle were normal and painless, and there was no fluid in the joint. The left elbow was swollen, and the swelling extended down the forearm for two or three inches. It felt like bony thickening of the ulna, but fluid could be felt distending the capsule of the joints posteriorly. There was no pain on movement, which was quite free. The heart, lungs and abdomen were healthy. The Wassermann reaction was negative on the first examination. An X-ray photograph of the joints showed the bony changes in the tibia and ulna, and evidence of periosteal thickening in the tibia. Dr. Parkinson believed the disease to be syphilitic in origin, and intended to have another blood examination made.

CLINICAL SECTION.

May the 9th, 1919.

Case of Lymphadenoma: Arsenical Pigmentation.—Dr. E. O'Flynn.—The patient was a boy, aged 10 years, who had attended hospital in 1916 for enlarged glands of the neck. On admission in 1917 the glands were thought to be tuberculous, until an operation was performed and one of the glands microscoped. The changes in the gland consisted of an increase of fibrous stroma, diminution of lymphoid tissue and presence of large lymphadenoma cells. The only other illnesses from which he had suffered were herpes zoster and chickenpox. During his stay in hospital arsenic was administered by the mouth (Fowler's solution), in gradually increasing doses from 6 minims to 30 minims daily. He became intolerant to arsenic; this

was shown by gastric symptoms—*i. e.* nausea. Smaller doses were again tried and were tolerated. Total arsenic in three weeks, 5½ dr. Pigmentation was noticed at the end of the patient's stay in hospital. The old herpetic spots, however, remained unpigmented. In addition to arsenic the patient was treated by X-ray exposures and intramine. A slight temporary improvement ensued.

Subsequent history.—The patient was admitted to St. George's Hospital in February, 1919, with pneumonia. He was extremely ill for one week. The crisis occurred on the eighth day and he then made an uninterrupted recovery. During this period no alteration took place in the glands. For about three to four weeks after the pneumonia there seemed to be some diminution in the size of the neck, measurements varying between 39½ and 40½ cm. There had been slight pyrexia varying between 99° and 100° F. The treatment had since consisted of the internal administration of phosphorus and benzine, and at present he was receiving intravenous injections of arsenic (novarsenobillon). Blood-count: reds, 4,704,000 per c.mm.; whites 9,440,000 per c.mm.; hæmoglobin, 65 per cent.; polymorphs, 57 per cent.; lymphocytes, 36 per cent; mononuclears, 6 per cent; eosinophils, 1 per cent. The general condition of the patient was better. Arsenical pigmentation as on admission.

The President (Sir Humphry Rolleston), said that Dr. Parkes Weber had made a collection of cases suggesting that pneumonia was prone to occur in persons taking arsenic, but that such cases of pneumonia ran a favourable course. The President was inclined to think that the evidence of acute pneumonia, when it occurred, might be connected with the presence of lymphadenomatous glands at the root of the lungs, apart from the use of arsenic. The improvement in the condition of the lymphadenomatous manifestations thought to occur in this case raised the question of the curative effect sometimes exerted by one disease on another—for example the beneficial effect of erysipelas on carcinoma of the mamma and the effect of Coley's fluid, composed of mixed toxins of streptococci and *Bacillus prodigiosus*, on sarcoma. Dr. Harry Campbell had recorded a case of malignant disease of the liver in which intercurrent influenza was followed by apparent disappearance of the hepatic disease, but eighteen months later the signs of malignant disease of the liver returned and the patient died. The association of abdominal pigmentation with leucodermia, possibly due to herpes zoster, in Dr. O'Flynn's case at first sight suggested that the pigmentation and the herpes were both due to the arsenic, as was abundantly demonstrated during the epidemic outbreak of arsenical poisoning occurring among beer-drinkers in the north of England and the Midlands in 1900. In his account of this outbreak Dr. Reynolds, who was first led to suspect its arsenical origin by the occurrence of herpes zoster, found that the pigmentation often showed well-marked lighter spots like rain-drops. In the present instance the history given by the boy's mother was very vague, but it appeared probable that if he had herpes it was before the course of arsenic.

SECTION OF DERMATOLOGY.

May the 15th, 1919.

Case of Leucodermia and Melanodermia Associated with Leuconychia.—Mr. H. C. Samuel.—The patient was a boy, aged 6 years. The left lower costal and lumbar regions showed a melanodermic sheet upon which were small leucodermic spots arranged in lines. On his nails were some early spots of leuconychia. The elder brother also exhibited the early stages of leuconychia striata on several of the finger-nails. The father had recently developed well-marked leucodermia and melanodermia at the angle of his lower jaw; they were not at all unlike those on the boy's trunk—that is to say, there was a melanodermic patch with small dotted macules of leucodermia upon it. In addition the father showed some leuconychia of his fingers. The father's brother had very well-marked leuconychia striata of all his finger-nails. Mr. Samuel was unaware that there was any association between leucodermia and leuconychia as shown by this case, although he believed it was not unknown between alopecia areata and leuconychia, and of course leucodermia, alopecia and canities were very frequently found together. So that there might be an indirect association between leucodermia and leuconychia. He would also be interested to hear from members whether they had ever, either in their own experience or that of their colleagues, any record of such a marked family history of leuconychia? What was the pathology of leuconychia? Neither of the two cases suggested that it was due to the presence of air in the nails, which had been suggested as the explanation of the whiteness.

Dr. F. Parkes Weber said he did not know of any case (excepting Mr. Samuel's) showing the association of leucodermia and leuconychia. The leucodermia in this case was of a very peculiar appearance, and it would be interesting to watch its progress. It did not look like the commencement of ordinary vitiligo.

Case of Angioma Serpiginosum.—Dr. A. M. H. Gray.—The patient was a girl, aged 4 years, apparently in perfect health. There was no personal nor family history which appeared to have any bearing on the present condition. At the present time she had a patch extending from the junction of the middle and lower thirds of the left leg, up the thigh, almost to Poupart's ligament, and occupying the front and inner aspect of the limb. The mother stated that a small patch, about the size of a threepenny-bit, was present at birth in the lowest part of the present patch, and that it had gradually spread upwards, and that progress still continued. On casual examination the patch seemed to be composed of dilated capillary vessels, the whole presenting a reticulated appearance. On closer examination, however, the lesions were seen to vary according to their age. In the newest part of the patch—namely, the upper edge of the thigh—the elementary lesions were seen to consist of slightly raised angular papules, best seen by reflected light. They were of the colour of the surrounding skin and occurred in groups, presenting a tessellated appearance. The angular outline was obviously produced by the natural lines of the skin, as in lichen planus, which it closely resembled. Underlying these papules vascular points or small dilated vessels, which disappeared on pressure, could be seen. In the region round the knee a further stage of development was noticed; the

centres of the groups noted above had cleared up, leaving apparently normal skin, while surrounding each of these areas, which did not usually exceed 1 cm. in diameter, a raised margin was seen containing vascular points and dilated capillaries. In the oldest lesions—namely, those at the lower and inner border of the large patch—these circular areas were still visible, but the raised margin had now become paler and fewer vessels were present. The pale raised margin had now a keloidal appearance as though some acid had been poured irregularly over the part, but no induration could be felt on palpation. So far no biopsy had been performed, so no account of the histology of the case could be given. The diagnosis was by no means clear. In most cases of angioma serpiginosum the lesions were all of the "cayenne pepper grain" type and not mixed with ordinary telangiectases as they were in this case. On the other hand, this slowly spreading vascular growth with its reticular distribution had many features of the "angioma serpiginosum" cases, and was unlike the systematised vascular nævi.

Two Cases of Epidermolysis Bullosa Hereditaria.—Dr. G. Pernet.—The patients were a boy, aged 7 years, and a girl, aged 5 years, brother and sister, who attended the West London Hospital recently for scattered pus lesions, but underlying this the condition of epidermolysis was noticed. The legs were mainly affected by the latter. The fingers were not involved. The mother stated that there were ten children in the family and five of them were or had been affected in this way. All were males except the present girl. The two eldest brothers, aged 30 and 29 years, were said to have "grown out of it," and were married. Another son, aged 23 years, was still a sufferer. The father suffered from the same condition as a boy, but he "grew out of it" too.

June the 19th, 1919.

Case of Dermatitis Herpetiformis.—Dr. A. Eddowes showed a boy who had suffered from the eruption for two years. Last winter it did not disappear, but during the previous winter it was much better. He complained of intense itching, especially at times. When he first saw the patient and observed these pigmented nodules with very little sign of scratching he thought it was urticaria pigmentosa, but on watching the case a little later he concluded it was dermatitis herpetiformis. There was a very symmetrical distribution and the lesions did not occupy the common sites; the patches were mainly over the sternum and clavicle and below the umbilicus. The fact that the lesions were chiefly papular and nodular was against the case being one of dermatitis herpetiformis. No vesicles or bullæ had been seen so far.

In the subsequent discussion Dr. Whitfield expressed the opinion that the child had pruritus of internal origin, probably kept up by scratching. He recommended syrup of calcium lacto-phosphate, which was much more efficacious and palatable than calcium lactate or chloride, and a local application of liquor carbonis.

Dr. Pringle thought that the case was an example of acne urticata, which usually occurred in neurotic women. Neither the elementary lesions, their grouping nor their general characters were those of dermatitis herpetiformis.

October the 16th, 1919.

Unilaterally Distributed Molluscum Fibrosum Tumours with a History suggesting Recurrence.—Dr. E. G. Graham Little.—The patient was a boy, aged 12 years. Two years ago he had had a warty growth similar to the present tumour removed by excision, and the scar still remained very conspicuous. About 1½ in. below this scar there were a number of molluscum fibrosum tumours over an area of about 3 in., one large one about the size of a mandarin orange, and several smaller ones immediately adjoining it. All had the same character of soft tumours of the skin. There was no ulceration or other change, but the increase in size had been rapid.

Folliculitis Ulerythematosa Reticulata of MacKee and Parounagian.—Dr. E. G. Graham Little.—Dr. Graham Little showed a case which was identical with that described by MacKee and Parounagian ('Journ. Cut. Dis.,' 1918, xxxvi, p. 339). The patient was an Irish boy, aged 15 years, somewhat small for his age but in excellent health. On both cheeks over the malar eminence and nowhere else was an area of skin about the size of a half-crown, in which the sole obvious change was the presence of tiny, pitted depressions like the surface of pumice-stone. Here and there in this area were a few comedones filled with hard, horny plugs, which were dislodged with some difficulty. They could not be extruded with an ordinary comedo extractor, and were much harder and more superficial than acne comedones. There was not and never had been any pustulation or inflammation and there was no sign of any erythema at present. The boy stated that he had had the lesions at least five years, and that the majority of the pitted depressions were not preceded by comedo formation. They caused absolutely no subjective symptoms, and the appearance supplied the only reason for troubling about the condition. MacKee's alternative title for the condition was "folliculitis atrophicans reticulata."

In the subsequent discussion Dr. Pernet stated that he had published a case of this type under the name of "atrophiculodermia reticulata symmetrica faciei" (*vide* British Journal of Children's Diseases, 1917, xiv, p. 213).

SECTION OF OBSTETRICS AND GYNÆCOLOGY.

June the 5th, 1919.

A Case of Congenital Teratoblastoma of the Vulva (Rhabdomyoma).—Mr. Gordon Ley.—A female infant, aged 5 weeks, was brought to him with the following history:

At birth a large tumour was noticed by the midwife replacing the vulva. The child was taken to a medical man, and the condition was pronounced as incompatible with life. The child was eventually brought to Mr. Gordon Ley when she was five weeks old. The tumour had increased considerably since birth, and in part its surface had ulcerated.

On examination there was a large tumour lying beneath the skin of the mons veneris, labia majora, vestibule, the anterior parts of the labia minora

and the clitoris, displacing these structures forward. Projecting posteriorly behind the urethral orifice, which was seen to be a slit slightly to the right of the midline, was a soft reddish-brown superficially ulcerated mass, which projected forwards, and had a deep attachment passing posterior to the urethral orifice. On lifting up the tumour there appeared to be a vaginal orifice in the form of a transverse slit, extending the whole width of the posterior margin of the tumour. Mr. Gordon Ley came to the conclusion that it was a congenital tumour, probably teratomatous, growing from the region of the floor of the urethra, and decided that the child would certainly die as a result of ulceration of the tumour if left, and might conceivably recover if the tumour was successfully removed.

On December the 20th he excised the tumour, with its pedicle, which included the urethra itself, and brought down the neck of the bladder, stitching it to the surrounding skin and posteriorly to the greatly widened vaginal orifice. The child stood the operation extremely well, but suffered severely from shock about half an hour later, and died suddenly.

Autopsy.—The infant was small and poorly nourished. The bladder, or urethral orifice, had a circumference of 0·7 cm., and admitted a large probe. There was no thickening or sign of tumour-tissue in the lower urinary outlet, nor elsewhere in the uro-genital tract.

The vaginal orifice was 1·5 cm. in diameter. There was very slight hypertrophy of the bladder and very slight dilatation of the renal pelves. There was anæmia of lungs and all organs.

Examination of the tumour showed that it contained fibrous interstitial tissue, involuntary and voluntary muscle and nerves. The fibrous tissue was somewhat embryonic in type. A great part of the voluntary muscle was certainly embryonic, having a homogeneous core containing numerous nuclei, whilst contractile fibrils were confined to the periphery.

SECTION OF OPHTHALMOLOGY.

March the 28th, 1919.

Cirsoid Aneurysm of the Orbit.—Mr. H. Grimsdale showed a boy, aged 13 years, who had a tumour just above the orbital margin, spreading up under the skin for half an inch. It seemed to be connected with the supraorbital vessels. It ceased pulsation when the carotid on that side was compressed. The boy was otherwise healthy and had had no accident. The provisional diagnosis of cirsoid aneurysm proved correct at the time of operation. An incision was made just below the orbital margin and the enlarged supra-orbital artery secured. Through other small incisions above the swelling three other branches connected with it from the other side were secured, one of these being connected with the anterior temporal. The pulsation ceased for two days and returned; the anterior temporal was then tied and the main sac removed. Some twenty small arterial trunks were secured during the dissection. Since the second operation there had been no return of pulsation.

Société de Pédiatrie, Paris.

January the 21st, 1919.

The Society held its first meeting on this date since June the 9th, 1914 (*vide* British Journal of Children's Diseases, 1915, xii, *p.* 337).

Rheumatoid Arthritis and Congenital Syphilis.—M. Méry and Mme. Génin recorded a case of rheumatoid arthritis in a female infant aged 1 year, in whom the symptoms first appeared at the age of six months. On admission to hospital the child presented multiple deformities of the joints, the lesions involving both elbows and wrists, the inter-phalangeal joints of both hands, both ankles, and the metatarso-phalangeal joints. Both the liver and spleen were enlarged.

Ophthalmoscopic examination showed nystagmus, absence of the light reflex and chorio-retinitis in both eyes. Von Pirquet's reaction was negative and the Wassermann reaction strongly positive. The cerebro-spinal fluid was chemically and cytologically normal.

After ten injections of biniodide of mercury considerable improvement took place, the fluid in the joints disappeared, and the movements became more free.

In the subsequent discussion M. Lesné reported the case of a child aged 13 months, with rheumatoid arthritis of the knees, elbows and fingers. The child showed no signs of congenital syphilis, and Von Pirquet's reaction was definitely positive. Death took place at the age of three years from tuberculous meningitis. The child's parents were both suffering from pulmonary tuberculosis.

Subcutaneous Injections of Milk in Infantile Dyspepsia.—Prof. E. Weill recently had under his care three infants, aged from 1 to 4 months, who had an absolute intolerance for their mothers' milk, profound vomiting occurring immediately, or soon after it had been swallowed. The vomiting was not accompanied by any circulatory or nervous symptoms, such as pallor, collapse, meningeal reaction, or eruption. The mothers themselves were in good health and their milk was satisfactory in quality and quantity. Two of the children could take cow's milk without vomiting. One child was given to another nurse who was successfully suckling her own child, but the milk was no better tolerated than that of the mother. On the assumption that the intolerance might be due to anaphylaxis Weill undertook an anti-anaphylactic vaccination by injecting the children with their mother's milk; 5 to 10 c.c. of milk, which had been sterilised for twenty minutes at 110° C., were injected. In two cases the vomiting stopped immediately, and in the third there was a considerable diminution in the vomiting, which ceased entirely after a second injection. In a fourth case subcutaneous injection of mother's milk rapidly stopped diarrhœa with green stools, and in forty-eight hours the stools became normal. It is noteworthy that one child who could previously take cow's milk showed an absolute intolerance for it after subcutaneous injection of mother's milk.

Transverse Myelitis following Measles.—MM. d'Oelsnitz and L. Cornil reported a case of transverse cervical myelitis in a boy, aged 4 years. During an attack of measles the child complained of constant

pain in all four limbs, which was increased by movement or pressure. When he began to get up the parents noticed he was unable to use his arms, and at the same time a progressive muscular atrophy of all his limbs was observed. On making the child walk a marked stiffness of the limbs was seen, which gradually increased until three months after the onset, when a slight improvement occurred, both in the flaccid paralysis of the upper limbs and in the spasticity of the legs. Two months after the onset there was retention of urine followed by transient incontinence. The absence of any motor defect in the upper root zone (C_5, C_6) as well as in the lower root zone (C_8, D_1) indicated that the lesion had affected the spinal segment corresponding to C_7. The painful symptoms noted at the onset were attributed to a temporary involvement of the roots or nerves in the inflammatory process similar to what occurs in some cases of infantile paralysis.

February the 18th, 1919.

Lethargic Encephalitis simulating Mumps Meningitis.—M. H. Grenet reported a case of lethargic encephalitis in a boy, aged 14 years, which was characterised not only by the ordinary symptoms such as somnolence, ptosis, squint, inequality of the pupils, paralysis of the frontalis and orbicularis oris, but also by slight swelling of the parotids, cerebro-spinal lymphocytosis, trismus and erythemato-pultaceous stomatitis. Mumps seemed to be excluded by the fact that though the patient was not isolated none of the seven other children in the family developed mumps. Netter had seen similar cases.

In the subsequent discussion M. Comby expressed the opinion that the case was really a sporadic case of mumps complicated by meningitis.

Congenital Rickets.—MM. Méry and Pastenier in October, 1908, showed a case of congenital rickets in a child aged 6 weeks (*vide* British Journal of Children's Diseases, 1908, v, p. 535). The child presented a rickety rosary, Harrison's grooves, bowing of the tibiæ and certain secondary symptoms suggestive of achondroplasia. At the present meeting the speakers reported on the naked eye and microscopical examination of the case, which had died shortly after it had been shown. There was nothing abnormal in the lungs, heart or alimentary canal. There was slight cirrhosis of the liver of the periportal type. The kidneys and suprarenals were normal. One testis showed interstitial sclerosis and periarteritis. The thyroid showed very definite interstitial sclerosis. On opening the cranium an extensive extradural hæmorrhage was found. Microscopical examination of the right humerus showed the characteristic lesions of rickets.

Pulmonary Cavity in an Infant aged 20 days.—M. J. Crespin and Mme. Athias reported a case in an infant, suckled by its mother, who was suffering from pulmonary tuberculosis. Death, which was preceded by digestive disturbance, dyspnœa and vague signs in the lungs, occurred on the twentieth day. The necropsy showed an area of caseous pneumonia at the right base with a cavity in the hilar region the size of a hazel nut full of pus containing tubercle bacilli. The tracheo-bronchial glands were not affected.

Sudden Death from Typhoid Fever in an Infant aged 3 months.—M. J. Crespin and Mme. Athias.—The infant was being suckled by its

mother, who was ill with typhoid fever. Owing to the severity of the attack the child was weaned, and though in the course of ten days it lost nearly a kilo in weight, its general condition appeared to be good, when one morning it was found dead in bed. The autopsy showed enlargement of Peyer's patches and mesenteric glands, slight enlargement of the spleen and a hæmatoma of the left suprarenal. The case illustrated the latent course of typhoid fever in the infant, and was a further proof of the close association between suprarenal hæmorrhage and sudden death.

March the 17th, 1919.

Generalised Infections Treated by Auto-vaccines.—Mlles. DE PFEFFEL and HOCHBERG reported three cases in children of acute or subacute infection of the skin or subcutaneous tissue which were treated with vaccines prepared according to Wright's method. The first case was an example of multiple streptococcal abscesses of all four limbs in a girl, aged 13½ years. Subcutaneous injections of anti-streptococcal serum and collargol and electrargol intravenously had no effect, but rapid improvement took place after two injections of an auto-vaccine containing 250 million organisms. The second case occurred in an infant aged 12 months suffering from generalised staphylococcal pyodermia. Two injections of an auto-vaccine were given, each containing 250 million organisms, without any effect on the general or local condition. After a third injection of 750 million organisms a generalised vaccinal reaction occurred in the form of folliculitis. When seen twelve days later the skin was much clearer. Two more injections each consisting of 500 million organisms were given, with an interval of six days between each injection, and were followed on each occasion by considerable improvement. Five days after the last injection the child developed enlargement of the retro-sterno-mastoid glands and eczema of the scalp, and died two days later, probably from acute renal insufficiency. An autopsy was refused. The third case, which occurred in an infant aged 7 months, was also an example of staphylococcal pyodermia, but was cured within a week by a single injection of an auto-vaccine containing 250 million organisms.

April the 15th, 1919.

Sporotrichosis Septicæmia with Cerebral Localisation.—MM. LESNÉ and LE BOUEDEC reported the case of a boy, aged 4 years, presenting multiple lesions of sporotrichosis, who suddenly began to suffer from vomiting and headache with a slow pulse followed by drowsiness, and Jacksonian epilepsy, starting in the right arm. The cerebro-spinal fluid was normal. Death took place after two months' illness. In spite of the absence of an autopsy it was probable that the cause of death was an intra-cerebral abscess due to the sporotrichum.

Tuberculosis Contracted by Infants in a Hospital Crèche.—MM. NOBÉCOURT and J. PARAF reported two cases of infants who contracted tuberculosis in a hospital *crèche*. One, aged 12 months, developed adenitis of the tracheo-bronchial glands, which showed a tendency to clear up, while the other, aged 6 months, contracted tuberculous broncho-pneumonia secondary to tracheo-bronchial infection and rapidly succumbed. The disease could not have been congenital, as the mothers who suckled the infants did not show

any signs of tuberculosis, but was obviously acquired ; and as the infants had never lived elsewhere than in the *crèche* they must have been infected there. All the staff were healthy, but several infants admitted in previous years had shown tuberculous lesions post mortem. The patients therefore had developed the infection from living in a contaminated environment. In the *crèche* in question numerous factors appeared likely to favour infection, viz. lack of isolation, difficulty of ventilation, deficient cubic space and overcrowding.

Aural and Nasal Complications of the Influenza Epidemic of 1918–19.—M. Abrand stated that otitis, which was extremely frequent in children in the course of the small epidemics of influenza between 1905 and 1914, was relatively rare in the recent epidemic until it began to decline, when numerous cases of severe otitis occurred. Suppuration took place rapidly, and paracentesis was required at once. Another complication which was usually uncommon in children and had since become more frequent was acute purulent ethmoiditis, which was manifested by a profuse discharge of pus or muco-pus and a widening of the upper part of the nose with or without pain on lateral pressure. Another frequent manifestation of influenza in the recent epidemic was glandular fever, which was characterised by a soft enlargement of the cervical glands with moderate fever and gastric disturbance.

Morbid Anatomy of Cephalhæmatoma. — MM. G. Variot and J. Bouquier described the post-mortem lesions in two cases of cephalhæmatoma. In the first case, which showed a typical cephalhæmatoma of the right parietal, the pericranium was still slightly raised by the collection of blood. The diploë in the central part of the right parietal was much thinned. On the other hand the bony radiations starting from the centre of ossification were very visible in the healthy parietal and the bone was thicker. But the striking feature of the specimen was that not only was the parietal bone thinned, but that it presented numerous holes resembling those made by a needle, especially at the anterior superior part in an area of about 1 sq. cm. In the second case the right parietal showed small holes very similar to those in the first specimen. None of the fissures or cracks in the outer table mentioned by some writers were seen. The speakers considered that a direct relation existed between the presence of the holes, which were most marked in the region of the hæmorrhage, and the effusion of blood. The holes doubtless corresponded to medullary spaces containing the blood-vessels which gave rise to the hæmorrhage. Delay in ossification, which appeared to be the primary factor, would be more likely to give rise to a tearing of the blood-vessels when the pericranium was being separated during labour. The mechanism of cephalhæmatoma therefore appeared to vary in different cases. In some there were cracks and fissures, and in others a special dysostosis which appeared to be a predisposing cause of hæmorrhage.

May the 20th, 1919.

Treatment of Pneumococcal Empyema in the Infant with Specific Serum.—MM. P. Nobécourt and J. Paraf reported three cases in infants aged from 2–5 months suffering from broncho-pneumonia complicated by empyema due to pneumococcus type II which was isolated from the pleural

fluid and naso-pharyngeal mucus. Treatment consisted in evacuation of the pus followed by intra-pleural and intra-pulmonary injection of 5 c.c. and 3 c.c. respectively of antipneumococcal serum. In one case intravenous injections of the serum were given as well. The injections were repeated from three to five days and were followed by considerable improvement in each case. All recovered from the pneumococcal infection, but in one death was due to cachexia and pyodermia.

Suppurative Arthritis due to Paratyphoid B Infection.—MM. Netter, Mozer and Salanier reported four cases of suppurative arthritis in infants in which paratyphoid B bacilli were found in the pus. Their conclusions were as follows: the paratyphoid B bacillus may occur in pure culture in suppurative arthritis. This form of arthritis appears to be most frequent in infants, in whom it attacks one or several joints. It may clear up without leaving any organic or functional disturbance and without any surgical intervention. As a rule paratyphoid suppurative arthritis occurs in the course of an infection accompanied by digestive and respiratory symptoms. In some cases the joint manifestations of paratyphoid B may be of a milder character and not end in suppuration. The condition is then liable to be mistaken for rheumatism.

Indigenous Amœbic Dysentery in a Child.—MM. Lesné and Ramond reported a case in a boy, aged 10 years, who had had attacks of dysentery since the age of 3 years. The child had never left France, and the infection was probably due to the fact that for three months he had been under the care of an Egyptian nurse, about whom no details could be obtained but who was probably a dysentery carrier. The true nature of the disease remained unrecognised for seven years owing to the absence of parasites in the stools. When the amœba was finally discovered, treatment by novarsenobenzol, emetine and ipecacuanha was instituted and recovery took place.

In the subsequent discussion similar cases of indigenous dysentery in children successfully treated by emetine were described by MM. Apert and Barbier.

Hæmophilia and Hæmarthrosis with Separation of the Femoral Epiphysis.—M. J. Génévrier reported a case of hæmophilia in a boy, aged 10 years, whose grandfather and brother were bleeders while the mother and sister showed no signs of the disease. The anæmia was very pronounced, especially after the hæmorrhage, when the total number of red cells fell to 2,000,000 and the hæmoglobin to 45 per cent. The coagulation-time was much prolonged and the clot was irretractile. The remarkable feature of the case was that after an injury to the knee a considerable swelling developed, but as the pain was not worse than on previous occasions medical advice was not sought until three weeks after the accident. A considerable effusion into the joint was then present and an unusual thickening of the femoral epiphysis was found. On X-ray examination separation of the epiphysis was seen. After continuous extension for three months, during which no futher hæmorrhages took place and the red cells increased to 4,600,000, the movements of flexion at the knee-joint became complete while those of extension remained limited. A silicate apparatus was then applied so as to enable the child to walk. The future functional capacity of the knee appeared uncertain. Although separation of the epiphysis was common in Barlow's disease, Génévrier was not aware of any previous case on record in hæmophilia.

Syphilitic Ulceration of the Umbilicus in an Infant.—MM. P. Nobécourt and J. Paraf reported a case of syphilitic ulceration of the umbilicus in an infant aged 5 weeks, which, apart from cachexia, presented no other signs of congenital syphilis. The Wassermann reaction, however, was strongly positive both in the mother and child, and the lesion was beginning to heal under specific treatment when death took place from broncho-pneumonia.

Abstracts from Current Literature.

Diseases of Respiratory System.

Fœtal bronchiectasis (*'Amer. Journ. Dis. Child.'* 1919, xvii, *p.* 95).—**H. L. Koeckert** reports a case in a newborn child who died from dyspnœa an hour and a-half after birth. At the autopsy the lower left lobe presented an atelectatic appearance, and the upper left lobe showed a large air- and fluid-containing cyst, the composition of the fluid closely resembling liquor amnii. No connection between the cyst and a bronchus could be found. The right lung was normal. The right ventricle was hypertrophied. No other abnormalities were detected. The cause of fœtal bronchiectasis is unknown, but the current opinion is that it is due to a primary maldevelopment. J. D. Rolleston.

Bronchial asthma in children (*'New York Med. Journ.'* 1919, cix, *p.* 503).—**W. H. Donnelly**.—The ætiological factors are heredity, adenoids and enlarged tonsils, bronchitis, enlarged bronchial glands, dust, cold and damp, indigestion, constipation, pollen or animal protein. In many cases it is a manifestation of a food anaphylaxis, from egg, fats and sugars. An enlarged thymus may have a mechanical action. Treatment consists in removal of enlarged tonsils and adenoids, careful diet, avoiding cream, eggs and sweets. Calcium chloride is recommended by Abt—3-4 gr. four times daily between the attacks. Kiemern recommends sodium bicarbonate and sodium salicylate. The author recommends aspirin. The skin test for proteins may indicate the offending body, to which the patient is specially sensitive. Attention shonld be paid to general hygiene.
J. Porter Parkinson.

Latent pneumothorax in the child (*'Thèses de Lyon,'* 1916–17, *No.* 32).—**M. T. Champy**.—The thesis contains the histories of nine cases, four of which are original. Six occurred in children aged from 14 to 30 months. The pneumothorax was chiefly found as a complication of pneumonia in association with a pleural effusion. It is sometimes caused by the opening of a pneumonic abscess into the pleura, which chiefly occurs in caseous pneumonia. The time of appearance of latent pneumothorax complicating pneumonia varies, but does not appear to occur later than the second week. Latent pneumothorax also occurs in pleurisy and pulmonary tuberculosis. The symptomatology is almost entirely negative. The only physical signs are the tympanic note, amphoric breathing and metallic tinkling which were

sometimes present, but were inconstant and ill-marked. Radioscopy gives an absolutely characteristic picture of latent pneumothorax, without which the diagnosis cannot be established. The presence, however, of an excessively thickened pleura may render the examination negative. In some cases the pneumothorax does not seem to have considerably modified the course of the original disease, but as a rule it aggravates the prognosis by causing a purulent change in a serous effusion or by suppressing a more or less extensive surface of the lung as the result of compression.

J. D. Rolleston.

An interesting case of measles, whooping-cough, pneumonia, pneumothorax; recovery (*'Practitioner,'* 1918, ci, *p.* 55).—**S. Matthews.** —A girl, aged 7 years, became ill with measles on January 1, 1918. Pertussis developed on the 31st, broncho-pneumonia on February 10, with a temperature of 106° F. on the 14th. On March 10 a sudden access of pain after coughing produced pneumothorax in the left lower back of the chest. March 11: The apex-beat was found in the right axillary line. On April 14 the physical signs had disappeared, and on May 1 the child was running about. The treatment consisted of keeping up the child's strength and unlimited supply of oxygen. F. R. B. Atkinson.

Report of a case of chylothorax (*'Arch of Ped.,'* 1917, xxxiv, *p.* 929). —**G. R. Pisek** reports a case in a female infant, aged 9 months—probably the youngest on record. There were no symptoms except very rapid and difficult breathing, with no temperature or cough. There was a distinct area of flatness over the right chest posteriorly, with corresponding diminution of breath-sounds and some displacement of the heart. Recovery took place after three aspirations of the chylous fluid in the course of three weeks.

J. D. Rolleston.

Empyema in children (*'Journ. de Méd. et de Chir. prat.,'* 1919, xc, *p.* 609).—**J. Comby** states that empyema is more frequent in children than sero-fibrinous pleurisy, contrary to what is observed in the adult. Of 140 cases in children seen by him in hospital and private practice, 28 were not recognised during life and 2 died without treatment. Of the remaining 110, 4 were treated by exploratory puncture, which was followed by spontaneous absorption, 29 by aspiration without pleurotomy, with 14 deaths, 63 by pleurotomy without resection of a rib, and 14 by pleurotomy with no resection. The 28 cases in which the empyema was not recognised during life were mostly very young children (between two months and two years of age), in whom the effusion was very slight, in most instances unilateral and complicated by broncho-pneumonia (15 cases), purulent pericarditis (2 cases), infective purpura (1 case), or phlegmasia alba dolens (1 case). In all these cases of unrecognised empyema death was not the result of the effusion itself, so that the error of diagnosis was not prejudicial to the patients. The mortality of cases treated by pleurotomy with or without rib-resection was 32 per cent., death, as a rule, being due to broncho-pneumonia (6 cases), pulmonary tuberculosis (2 cases), encysted empyema (2 cases), suppurative psoitis (1 case), suppurative pericarditis (1 case), and special virulence of the effusion (1 case). Comby has abandoned the practice of washing out the pleural cavity with sublimate, permanganate or hydrogen peroxide, but simply uses a large drainage-tube and applies sterilised gauze and wool. No obvious advantage was derived from the resection of a rib in the fourteen cases in which it was performed. J. D. Rolleston.

Empyema in children (*'Boston Med. and Surg. Journ.'* (1919, CLXXXI, p. 87.)—**F. S. Churchill** states that this condition is relatively infrequent in children. It occurred in 5 per cent. of 824 cases of lobar pneumonia and in $1\frac{1}{2}$ per cent. of 557 cases of broncho-pneumonia treated in the Children's Memorial Hospital, Boston, during the last ten years, while during the same period only 180 cases were found in the out-patient department, practically all undetected before their visit to hospital. The onset is insidious. It is practically never primary, but almost always secondary. The primary disease is usually pneumonia, but occasionally empyema may complicate measles, scarlet fever, bronchitis, appendicitis and acute arthritis. In all cases of pneumonia the probability of the development of empyema should be borne in mind, the danger-signals indicating its development being both general and local. In cases ending by crisis they may be noticed in from one to ten days after the crisis, while in cases ended by lysis they may develop imperceptibly. The diagnosis of empyema in infants and children is more difficult than in adults, and careful examination of the chest performed daily is often necessary to detect the condition. A displaced apex-beat is an important diagnostic sign. It is not, however, diminished in vigour as in pleuritic or pericardial effusions. The X-ray picture, though of help in locating a fluid, is not conclusive, as practically the same degree and shape of shadow may be produced by pneumonic consolidation or a pleuritic effusion, and a final decision can only be made by puncture of the chest, repeated if necessary.

J. D. Rolleston.

Treatment of purulent pleurisies by methylene-blue (*'Journ. de Méd. de Paris,'* 1919, XXXVIII, *p.* 152).—**P. Nobécourt, Jurine des Camiers** and **Tournier** use a solution of methylene-blue of 5 per cent. in sterilised water. After emptying the pleura 10 c.c. of the solution is injected very slowly. The injection is well borne, but sometimes for half an hour there is severe local pain which may be treated by morphia. The injection is followed by a fall of temperature and profuse sweating, and the methylene-blue appears rapidly in the urine. The results were remarkable, as in twelve severe cases ten were quite successful.

J. Porter Parkinson.

Hæmoptysis following exploratory puncture of the chest (*'Arch. of Ped.,'* 1918, XXXV, *p.* 524).—**A. Caillé** reports two fatal cases in infants, aged 6 weeks and 2 years respectively, death occurring immediately after the puncture in each case. In the first case the autopsy showed a patent foramen ovale, an opening in the interventricular septum, inflammatory consolidation of both lungs with marked congestion of the entire lung, and an extensive hæmorrhage into the right pleural cavity. The track of the needle could be followed for $\frac{1}{4}$ in. in the lower quadrant of the middle lobe, but no puncture of a large vessel could be made out. In the second case, in which there were signs and symptoms of right-sided pneumonic consolidation, no autopsy was permitted. In the first case a chronic congestive condition of the respiratory tract due to congenital heart defects existed from birth. In the second case extreme congestion of the lung was caused by pneumonic infection and consolidation accentauted by cardiac insufficiency as the result of two weeks' strain upon the heart of a feeble individual. In neither case was the hæmorrhage due to faulty technique.

J. D. Rolleston.

Pneumonia in early infancy and in childhood (*'Journ. Amer. Med. Assoc.,'* 1917, LXIX, *p.* 1661).—**H. Koplik** gives statistics of a large number of cases of pneumonia in childhood, and lays stress on the fact that the administration of alcohol is unnecessary in the treatment. He has had better results in the cases treated without alcohol than in those in which it was given. During the past two years, when no alcohol at all was given, the mortality of his 335 cases was 14 per cent. Serums and vaccines in the author's hands have been even less successful than in adults.

T. WHIPHAM.

Unusual hyperpyrexia in pneumonia (*'New York Med. Journ.,'* 1918, CVIII, *p.* 3).—**J. P. Crozer Griffith.**—The first case was in a girl, aged 2½ years, who had suffered from broncho-pneumonia for two weeks. The daily maximum varied from 104° to 107° or 108° F. The child recovered. The second case was one of croupous pneumonia in a boy, aged 5¼ years. The fever had been as usual till the seventh day when it rose to 109° F.; the pulse became rapid and small and the child appeared to be sinking, and warm mustard bath was given; in twelve hours the temperature had dropped as many degrees and the general condition was better. Convalescence was established by the thirteenth day. [A case of hyperpyrexia where the temperature rose to 110° F. on the fourth day was described in the BRITISH JOURNAL OF CHILDREN'S DISEASES, 1917, XIV, *p.* 112.]

J. PORTER PARKINSON.

The influence of cerebral symptoms on the prognosis in pneumonia in childhood (*'Glasg. Med. Journ.,'* 1919, I, *p.* 84).—**M. Putnam,** in a series of 120 cases of lobar and primary broncho-pneumonia in children, examined the effect of the presence of cerebral symptoms, especially the presence and influence of tetany, on prognosis, and concludes that when one meets with a case of pneumonia complicated by tetany the prognosis, apart from the caution which must always be used in making a prognosis in the spasmophilic diathesis, even when uncomplicated, need not necessarily be grave. In this series the mortality per cent. of cases without cerebral symptoms was 21, with early cerebral symptoms 10, with latent or active tetany 11, with active tetany 20, and with late cerebral symptoms 66.

J. ALLAN.

Pulmonary fibrosis (*'Lancet,'* 1918, I, *p.* 765).—**G. T. Hebert** describes non-tuberculous fibrosis of the lungs in childhood under three types: (1) Basal fibrosis with tendency to cure; (2) apical fibrosis; (3) fibrosis with commencing bronchiectasis. As an example, a boy, aged 13½ years, is described, who was regarded as being in good health until he was examined—presumably at a school inspection. His parents were informed that he was tuberculous, and he was confined in institutions for three years. The heart was displaced to the right. The right side was contracted, motionless and dull from apex to base. Patchy, tubular breath-sounds were heard over the middle of the right upper lobe and over the lower lobe; breath-sounds were obscured by creaking and explosive *râles.* During two and a-half years he gained 3½ st. in weight. Similar cases are described in girls between nine and twelve years of age, in one of whom purulent expectoration tinged with blood was noted. Temperature and pulse are not mentioned. An account of true tuberculous fibrosis is then given. In this case there had been loss of weight for six months. Her weight on

admission was 3 st. 12 lb. Tubercle bacilli were present in her sputum. The upper half of the left lung was affected, and there was cavitation at the left apex. The temperature was 100° F. and the pulse-rate 110. She died in eighteen months. The diagnosis depends on (*a*) history and appearance of patient. The cases of non-pulmonary tuberculosis often follow measles and whooping-cough, rendering them liable to recurrent attacks of bronchitis in the winter months. Some die from various forms of pneumonia; others acquire bronchiectasis or collapsed lungs. In a few, tuberculosis supervenes and fibro-tuberculosis results. On the other hand, children with true tuberculosis rarely live for more than twelve months and are definitely ill; 61 per cent. failed to improve in hospital, while nine cases of thirteen non-tubercular fibrosis improved. (*b*) Situation of disease: Non-tuberculous fibrosis is generally basal. Tuberculous fibrosis is invariably present in the upper part of one or both lungs. Bilateral apical signs always indicate tuberculosis. (*c*) Sputum examination: Children suffering from tuberculosis always bring up sputum containing tubercle bacilli. Tuberculosis from child to adult life passes through four stages: (1) Tuberculous processes in root-glands. (2) Changes in walls of air-passages—said, but not proved, to be tuberculous by radiologists. (3) Early tuberculosis of lung-tissue. (4) More or less advanced disease with tubercle bacilli in the sputum. The author concludes by saying that tuberculosis of the bronchial glands should not be classed with pulmonary tuberculosis in statistical returns, and that cases of tuberculous fibrosis should not be excluded from school.

CHRISTOPHER ROLLESTON.

Radiology of the thorax in children (*'La Pediatria,'* 1918, XXVI, *p.* 385).—**F. P. Sgobbo** examined thirty children—eighteen males and twelve females—between the ages of 5 and 10 years. In the first group of strong, healthy children, with no family history of tubercle, he found in most cases engorgement of the tracheo-bronchial glands without manifest symptoms. In the second group, with strong positive family history, all showed the hilus affected to a greater than in group 1, the seat of multiple glands, often confluent. Thus only 20 per cent. of healthy children with negative family history showed normal lymphatic mediastinal glands.

VINCENT DICKINSON.

The value of Hochsinger's sign in the diagnosis of infantile tracheo-bronchial adenopathy (*'La Pediatria,* 1918, XXVI, *p.* 88).—**S. de Stefano** describes his investigations with regard to this sign, which consists in the presence of small lymphatic glands in the fourth and fifth intercostal spaces between the anterior and posterior axillary lines. He found this sign present in 55 per cent. of the cases and indicative of broncho-adenopathy, while in 45 per cent. the presence of such glands, associated with other glandular enlargement, may be in relation also with other diseases, especially with hereditary lues, rickets and serious malnutrition. Hence this sign is of great diagnostic value only when it is associated with a positive cuti-reaction or when its presence is confirmed by the results of radiographic investigation.

VINCENT DICKINSON.

Tuberculosis.

Bovine tuberculosis in children (*'Amer. Journ. Dis. Child.,'* 1919, XVII, *p.* 264).—**R. S. Austin,** Pathologist to the Children's Memorial Hospital,

Chicago, examined 24 cases of tuberculosis in infants and children and found that 7 were caused by the bovine type. Determination of the bovine or human type of bacillus in each case was based on the result of inoculations of rabbits with known amounts of cultures. In 12 cases in which the primary focus was noted it was found in six in the right lung, in 2 in the left lung, in 3 apparently in a bronchial lymph-nodule on the right side, and in 1 case in the intestine. One of the bronchial node cases and the intestine case had bovine infection. The fact that 7 cases of bovine infection occurred, although all milk sold in Chicago is supposed to be pasteurised, points to the necessity of home pasteurisation of cow's milk.

J. D. Rolleston.

Bacillus tuberculosis in the tonsils of children clinically non-tuberculous (*'Amer. Journ. Dis. Child.,'* 1919, xviii, *p.* 14).—**R. S. Austin** examined the excised tonsils of forty-five children, aged from 2½ to 15 years, for the presence of tuberculosis by inoculation of guinea-pigs, histological examination of sections, cultures on Dorset egg medium and direct smears. In all cases the histological examinations showed no evidence of tubercle and no tubercle bacilli were found in any of the cultures or direct smears. The inoculation was positive in only one case, the organism being of the human type of the tubercle bacillus. Although tuberculosis of the tonsils in children is not rare, in most of the cases tuberculous lesions are found elsewhere in the body, especially in the cervical lymph-glands. The occurrence of the tubercle bacillus in the tonsils of children without clinical evidence of tuberculosis is not frequent. The discovery by Mitchell (*vide* British Journal of Children's Diseases, 1918, xv, *p.* 64) of tubercle bacilli in the tonsils of 13 out of 100 children without signs of tuberculosis was probably due to the fact that tubercle bacilli were prevalent in the Edinburgh milk supply, whereas the children in Austin's series came from a community where the supply of cow's milk was far less likely to be contaminated. Moreover, only two of his cases came from families in which there were cases of tuberculosis. J. D. Rolleston.

Latent tuberculosis in the infant (*'Riv. di Clin. Pediat.,'* 1919, xvii, *p.* 169).—**Spolverini** tabulates a series of positive results obtained by testing some 900 children with the cutaneous reaction during the first year of life. He begins by pointing out the great discrepancy between the results obtained by other investigators in the same field, Von Pirquet, for example, finding 16 per cent. positive of children tested between the ages of six and twelve months, and Di Stefano only 9 per cent. In the present series of 900 cases 63 gave a positive reaction. Of these 8 were between three and four months old, 22 between four and six months, and 33 between six and twelve months. In the majority of cases there was evidence of tubercular infection in the environment of the child, and he notes the frequency of the disease in the members of families living in one room. Inquiring into the age of the mothers he found that in half the cases the mother was between the ages of twenty and thirty, in one-third of the cases between thirty and thirty-five, and in one quarter between thirty-five and forty. These results, he states, agree with statistics already published by Karosj, who also noticed the frequency in cases of children of mothers between twenty and thirty. Examining the parity of the mothers he found 14 per cent. of his positive cases in the children of primiparæ, 7 per cent. were second children, 12 per cent. were third children, and 5 per cent. were later children. Contrary to

expectation he found a definite difference in the sex-incidence, two-thirds of the cases being of the male sex and one-third female. As regards feeding, artificially-fed children gave twice the number of infected cases that appeared with children on a mixed system. One-third of the infected cases appeared quite normal in general growth and development. Of the remainder, only 10 were breast-fed, 26 being partly breast-fed, and 6—the total number of this class—being entirely bottle-fed. He finds the usual method of infection to be by the route of the bronchial glands. He sums up by demanding an energetic anti-tuberculous campaign based on the facts that the child is not born tuberculous, that it is infected after birth, and that by removing it from an infected environment as soon as possible and placing it in a "pouponnière," where good sanitary conditions and feeding can be assured, the disease can be held in check. SIDNEY NATHAN.

Infection of children with the tubercle bacillus (*'New York Med. Journ.,'* 1918, CVII, *p.* 1018).—**E. M. Spill** investigated by the von Pirquet method the children living in the congested districts of the lower east side of New York. He found tubercular infection was rare under four years in children in healthy families. Thenceforward there was a steady increase up to the age of thirteen years. From the tenth to the twelfth year the percentage of infection was nearly three times that from the eighth to the tenth. Older children are more liable to infection from sources outside the family, but they are more resistant than infants under two. In a large proportion the cervical glands are the chief seat of the involvement, no doubt by way of the tonsils and adenoids. In a large percentage of cases the infection is of the bovine type. The X rays are of the greatest assistance in showing disease of the lungs or tracheo-bronchial glands.

J. PORTER PARKINSON.

The Mantoux reaction in children (*'Arch. of Ped.,'* 1918, XXXV, *p.* 714).—**O. Reiss** performed Mantoux's intracutaneous test with a solution of ·005 mg. old tuberculin and normal saline. Nineteen gave a positive reaction, which appeared as early as six and never later than twenty-four hours after inoculation. The lesion presented a central oval papule from 0·4 to 0·6 cm. long and from 0·2 to 0·4 cm. wide surrounded by an areola. The reaction usually reached its maximum in twenty-four to thirty-six hours, remained stationary for about twenty-hours and then gradually began to fade. The von Pirquet test was never positive when the Mantoux test was negative, but was negative in three cases which gave a positive Mantoux. J. D. ROLLESTON.

Cutaneous and intracutaneous tuberculin tests (*'Amer. Journ. Dis. Child.,'* 1918, XV, *p.* 313).—**M. H. Bass** performed 1165 tests on 206 children, aged from a few days to 6 years, and found that 52, or 25·2 per cent., gave a positive reaction. The following procedure was used: Each child was given a von Pirquet test, which was observed after 24, and again after 48 hours. If positive this was regarded as evidence of tuberculous infection. If negative after 48 hours, a second von Pirquet test was performed. After 48 hours a third test was made. If this, too, was negative, an intradermic injection of 0·1 c.c. of 1 : 1000 old Koch tuberculin in saline solution was used. If after 48 hours this was negative, 0·1 c.c. of a 1 : 100 solution was injected and repeated after 48 hours if negative. If after six tests the case still failed to react it was considered definitely negative. The

importance of re-testing negative cases is shown by the fact that if only a single von Pirquet test had been used the incorrect conclusion would have been drawn that only 3·3 per cent. of the inmates had been infected with the tubercle bacillus. If only two von Pirquet's tests had been used the percentage would have been doubled (6·8) and so on, until by the use of the intradermic tests the true percentage of infected cases was found to be 25·2. J. D. Rolleston.

The complement-fixation test for tuberculosis in infancy and childhood (*'Arch. of Ped.,'* 1919, xxxvi, *p.* 32).—**H. Heiman** performed complement-fixation tests for tuberculosis on the sera of seventeen tuberculous infants and children with Miller's and Petroff's antigen, and found that one gave 4 plus, one 2 plus and two suspicious reactions. Complement-fixation tests on the sera of five children probably but not definitely tuberculous were all negative with both antigens. In twenty-eight more tuberculous infants and children complement-fixation tests gave three 4 plus and two suspicious reactions. J. D. Rolleston.

The importance of papulo-necrotic tuberculides in the diagnosis and prognosis of infantile tuberculosis (*'La Pediatria,'* 1918, xxvi, *p.* 635).—**A. Gismondi** ably reviews this subject, including under this nomenclature of Darier the follicles of Barthèlemy and acnitis. From his observations he asserts that this form of skin disease is invariably an indication of a tubercular focus in the organism. While admitting that other cutaneous tuberculides—especially lichen scrofulosorum—may be benign, this special disease is of serious import, the majority of the cases dying within a relatively short time of some visceral form of miliary tuberculosis. Vincent Dickinson.

Hæmoptysis in children; report of five cases (*'Arch. of Ped.,'* 1918, xxxv, *p.* 526).—**P. H. Pierson.**—The ages of the children ranged from 5 to 9 years; four were girls and one a boy. The hæmoptysis in all the cases was probably due to pressure on and erosion of a vessel near the hilus by an enlarged tuberculous gland. The physical signs corresponded very definitely with the X-ray findings. There was always increased dulness over the hilus and possibly over the more affected lung, but this was not as prominent a sign as the increase in harshness of breathing. A musical quality in inspiration and expiration was of great importance as denoting a potentially active irritating process. J. D. Rolleston.

Variations in the leucocytes following artificial pneumothorax in childhood (*'La med. de los niños,'* 1918, xix, *p.* 332).—**F. de P. Casanovas** records two cases of pulmonary tuberculosis in children, aged 12 and 15 years respectively, treated by artificial pneumothorax, in whom the operation was followed by increase in the absolute number of leucocytes and in the number of the polymorphonuclears. In the first case before the operation the number of leucocytes was 8600 and of the polymorphonuclears 59, and two hours after the operation the leucocytes rose to 16,500, then to 20,800 and 21,400, and the polymorphonuclears to 80 and then to 93, returning to normal next day. In the second case the number of leucocytes before the operation was 7900 and of the polymorphonuclears 68, and after the operation the leucocytes rose to 29,700 and the polymorphonuclears to 82, the normal counts being found a week later. J. D. Rolleston.

The prognosis in tuberculous meningitis: report of a case (*'Arch. of Ped.,'* 1918. xxxv, *p.* 676).—**F. van der Bogert** states that true tuberculous meningitis occasionally ends in recovery. Martin, in 1909, collected 20 cases in which the diagnosis was confirmed by the presence of tubercle bacilli in the spinal fluid, by guinea-pig inoculation, by later post-mortem findings, or by the ophthalmoscope. Browning gave the number of undoubted cures reported up to 1914 as 80. They included, however, four of his own in which, according to van der Bogert, the diagnosis could not be accepted as confirmed. Van der Bogert's case occurred in a girl, aged 3½ years, in whom the symptoms indicating tuberculous meningitis were marked irritability and sensitiveness to external irritation, distinct neck rigidity and irregular remittent temperature. The spinal fluid showed lymphocytosis and two distinct tubercle bacilli. Inoculation of a guinea-pig with the fluid proved positive. Rapid improvement took place after the second lumbar puncture, and a slow but uninterrupted recovery took place. When seen six months after the onset the child was well though mentally excitable.

J. D. Rolleston.

On the clinical aspects of tuberculous mesenteric glands (*'Lancet,'* 1918, i, *p.* 869).—**H. W. Carson.**—Fordyce found tubercle bacilli in the mesenteric glands in 10 out of 50 post-mortems at the Children's Hospital, Edinburgh MacConkey found virulent tubercle bacilli in 10 out of 28 post-mortems. Carson, out of 50 cases, found pulmonary tuberculosis in only 2. The glands affected were those which drain the cæcum and ileum. The disease runs through three stages: (*a*) Enlargement of glands (15); (*b*) caseation of glands during which complications occur (25); and (*c*) calcification (6). The numbers in brackets refer to the distribution of variety in the present series; 37 of the cases occurred in persons under fifteen. The chief symptom is centralised abdominal pain, lasting for fifteen minutes at a time, recurring at intervals varying from a few hours to four weeks, and accompanied in about one-third of the cases with vomiting. The pain is due to colic set up by the stimulation by the glands of adjacent nerves. There is no tumour to be felt on palpation and no local tenderness. In chronic appendicitis the attacks of pain are less frequent, last longer, and may be localised. Local tenderness is marked, and there may be a rise of temperature during an attack. In ureteric stone the pain is unilateral, and is accompanied by vomiting and frequency of micturition. As to complications, intestinal obstruction occurred in 7 cases, either by direct pressure of the gland or by a Meckel's diverticulum or a band of omentum becoming adherent to the gland. Three cases of intussusception are recorded, due to stimulation of the vagus by the gland, causing contraction of the gut above and relaxation below. The treatment recommended consists of the removal of any oral or dental septic focus, the correction of constipation and removal by dissection of the enlarged glands and appendicectomy. Forty-seven cases recovered after the operation and 3 died. Thirty-three cases were followed up for years: 22 are quite well, 8 practically well, 2 have died without improvement, and 1 has been too recently operated on to deserve notice.

Christopher Rolleston.

Tuberculin therapy in children (*'Med. Record,'* 1919, xcvi, *p.* 459).—**R. C. Newton** records seven cases of tuberculosis in children aged from 6–19 years, nearly all of which showed very perceptible improvement with comparatively small or very small doses of tuberculin. Of four cases of

peritoneal tuberculosis, three were brought under treatment within a few weeks of the appearance of the ascites and prompt improvement occurred, while the fourth case took longer to recover. Excellent results were achieved in the tuberculin treatment of three cases of pulmonary tuberculosis that came under treatment within a few months of the beginning of active pulmonary lesions, while cases of older standing, although improving for a short time under tuberculin, failed to show a permanent arrest.

J. D. Rolleston.

Surgery.

Strangulated inguinal hernia in infants (*'New York Med. Journ.,'* 1919, cix, *p.* 233).—**J. E. Field**, in relating a case of successful operation on an infant, aged 14 days, gives the following reasons of the rarity of strangulation in infants' herniæ: their small size, the looseness and dilatability of the pillars of the external ring, and the fact that the hernia has not lasted long enough to contract adhesions to surrounding tissues. He warns mothers and nurses against giving castor oil when an infant shows signs of abdominal pain as he considers it was the cause of strangulation in this case.

J. Porter Parkinson.

Hernia across the lesser sac of the peritoneum (*'Glasg. Med. Journ.,'* 1919, i, *p.* 129).—**J. H. Pringle.**—A girl, aged 5 years, was operated on for acute intestinal obstruction of at least thirty-six hours' duration. The lowest ileal loop was found to be gangrenous, having been snared by a solitary band. A resection of bowel was made. The child died. At the post-mortem examination it was found that an internal hernia existed. Part of the jejunum was in the lesser sac of peritoneum. It was found that the mesocolon terminated along the arch of the colic arteries and that a large opening existed in the mesocolon corresponding to the arch. Through this opening one's fingers could be passed up behind the stomach to present under the gastro-hepatic omentum and also out to the spleen, but not down in front of the colon. When the stomach and colon were dragged upon in an upward direction the pancreas was lifted off the abdominal wall, and the splenic vein, with the inferior and mesenteric vein entering it, became visible. The transverse mesocolon terminated in two columns, that on the left side being very marked, while the one on the right side was rather less defined; they terminated at the origins of the middle and left colic arteries respectively. A male infant was operated on for acute intussusception of about twenty-four hours' duration. An ileo-colic intussusception was reduced. The infant died, and post mortem the arch formed by the middle and left colic arteries was remarkably prominent, and lay in a fringe of peritoneum which hung down from the transverse mesocolon in the form of a short mesentery. The mesocolon itself outside the arch was normal in texture and appearance; but the tissue bridging across the arch was of the thinnest possible character, being merely a thin, gossamer-like veil of membrane, entirely devoid of fat and without any visible vessel in it. It presented several small openings in it leading through into the lesser sac. When seen on lifting up the transverse colon this thin membrane presented quite a depressed saucer-like cavity, obviously by the highest loop of the jejunum. The inferior mesenteric vein was not seen.

J. Allan.

Diverticulitis and intestinal obstruction (*'Journ. de Méd. de Bordeaux,* 1919, xc, p. 355).—**Rocher** reports a case in a boy, aged 13 years,

in whom the extremity of Meckel's diverticulum, in which the lesions were probably most pronounced, became adherent to the mesentery, causing strangulation of two intestinal coils. At first the signs of peritoneal infection predominated similar to those caused by a slight attack of appendicitis, but subsequently the characteristic picture of intestinal obstruction developed. Operation was peformed on the ninth day. Recovery after resection of the diverticulum was uneventful.

J. D. Rolleston.

Appendicitis in the epigastric region (*'Gaz. hebd. des Sc. méd. de Bordeaux,'* 1919, xl, *p.* 374.).—**J. Brau-Tapie** records a case in a boy, aged 14 years, in whom, in spite of the presence of a definite McBurney's point, the cæcum and appendix were found, not in the right iliac fossa, but in the epigastic region. At the operation, which was performed twenty-three hours after the onset, the appendix was already gangrenous. Appendicectomy was performed and complete recovery took place. The writer attributes the displacement of the appendix to the shortness of the ascending colon.

J. D. Rolleston.

Adenoma of the small intestine with resulting volvulus (*'Brit. Med. Journ.,'* 1918, ii, *p.* 432).—**J. S. Manson** reports a case in a female infant, aged 8 months, who developed intestinal obstruction. At the operation an empty plum-coloured loop of intestine twisted to half a turn, and covered by adherent lymph, presented itself. The twist was undone and a small hard tumour was felt at the commencement of what was apparently the proximal part of the loop, and firmly attached to the intestinal wall. Owing to the collapsed condition of the infant no attempt was made to remove the tumour. Death occurred some hours later. Post-mortem the growth was removed, and was reported to be an adenomatous polypus.

J. Allan.

Intussusception, intermittent, due to congenital cyst; operation; death (*'Med. Journ. of Austral.,'* 1918, ii, *p.* 117).—**E. C. Moule.**—A girl, aged 4 years, had attacks of vomiting and stomach-ache for two days, which was diagnosed the next day as being due to intussusception. On operation the intussusception was reduced and a cyst in the colon opened. The child died fourteen hours afterwards. F. R. B. Atkinson.

A résumé of 51 cases of intussusception (*'Med. Journ. Austral.,'* 1918, ii, *p.* 383).—**P. L. Hipsley.**—Fifty of the cases were operated upon, and no death occurred when the operation was performed within thirty-six hours of the onset of symptoms. Four of the children died. One case was reduced about eight hours after the onset by means of injections of olive-oil and water under an anæsthetic. Forty-two of the 50 cases were in males and 8 in females. F. R. B. Atkinson.

Dislocation of the teeth (*'Lancet,'* 1919, i, *p.* 339).—**H. M. Savory** reports a case in a boy, aged 13 years, who received an accidental blow in the mouth from a stick. The two upper central incisors were completely dislocated, and fell out on being touched. There was considerable laceration of the soft parts. After the parts had been cleansed the teeth were replaced, the lacerations of the gum being stitched. The patient was furnished with a lint pad to bite on, and the jaw held up fairly tightly with a jaw bandage.

Pad and bandage were kept on for forty-eight hours. Six months later the condition was quite satisfactory, the boy being able to bite apples and tackle hard crusts without discomfort. J. Allan.

Chondro-fibro-sarcoma of the maxillary antrum treated with radium (*'Edin. Med. Journ.,'* 1919, i, *p.* 80).—**Dawson Turner** reports a case in a boy, aged 6 years. The disease, which caused protrusion of the cheek, diplopia and proptosis, was removed as far as possible by scraping. Later tubes of radium were introduced through an opening into the mouth, and a dose of 1440 milligramme-hours administered. Two and a-quarter years after the treatment the boy was reported to be quite well.

J. Allan.

Congenital osteosclerosis (*'La Pediatria,'* 1919, xxvii, *p.* 198).—**G. Di Giorgio** describes cases of a girl and a boy, aged 6 and 3 years respectively, with photographic and skiagram reproductions. The Wassermann reaction was negative in both and in the mother. The cases are interesting from the symmetry of the deformities and the perfect homology of the changes present in both subjects, and also from the familial type. They show the influence which consanguinity and the age of the parents may have on the offspring, the father being paternal uncle of the mother, the former 70 years of age, the latter 15. The anatomical changes consisted in a process of chondrodystrophy leading to agenesis of the whole of the articulation, causing osteosclerosis and complete ankylosis. Vincent Dickinson.

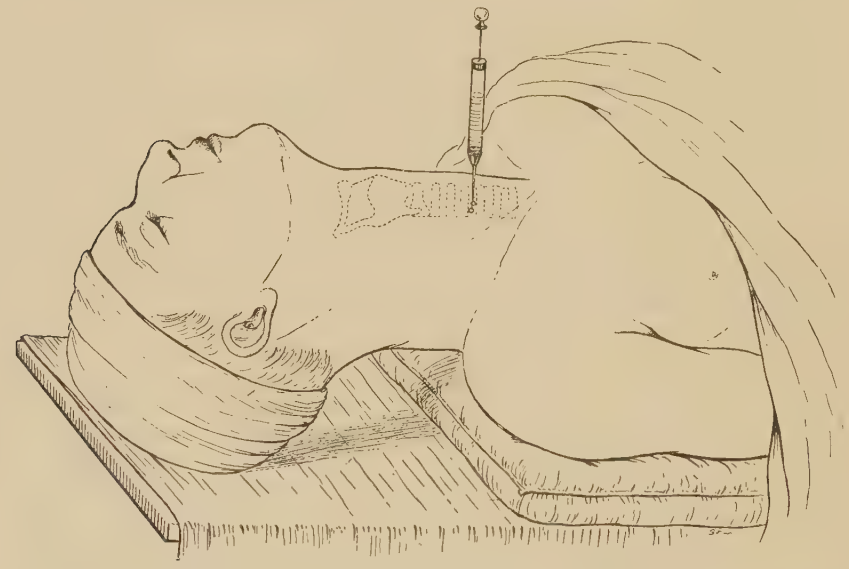
Fracture of the cervix femoris in children (*'Edin. Med. Journ.,'* 1919, i, *p.* 75).—**D. M. Greig** reports three cases in children, aged 2, 5 and 15 years respectively. The injury is liable to be overlooked, and the diagnosis should be confirmed by radiography. J. Allan.

Kohler's disease of the tarsal scaphoid (*'Boston Med. and Surg. Journ.,'* 1919, clxxx, *p.* 445).—**F. W. O'Brien** reports a case in a girl, aged 3 years, of this condition, which he defines as probably a non-infectious process seen only in children, and characterised clinically by swelling of the foot, pain on palpation and weight-bearing, usually without constitutional signs, and presenting a distinct X-ray picture and a good prognosis. The disease appears to be due to a delayed development of the ossific centre of the scaphoid, which is stimulated to osteogenesis by traumatism, and the pain and swelling may be due to post-traumatic osteitis. Less than twenty cases have been reported since Kohler first described three cases of the disease in 1908. Probably both before and since then the condition has frequently been mistaken for cold tuberculous abscess. The following X-ray appearances are characteristic: (1) The scaphoid is half to a quarter smaller than usual; its form is entirely regular. (2) Its architecture is impossible to recognise, cortex and spongy portion running together, and its density is increased two to fourfold. The prognosis is invariably good, and recovery takes place independently of treatment after lasting from two to three years. Most writers recommend rest and support in some form. J. D. Rolleston.

Curvature of the spine in growing children (*'New York Med. Journ.,'* 1919, cx, *p.* 1).—**E. H. Bradford** classifies them as follows: (1) Those due to faulty attitudes; (2) those with changed structure in the spinal column. The first class with little help grow to the normal type. In the second

class special treatment is necessary. Side tracings as well as contour tracings are necessary. Early treatment in increasing cases is of great importance. The general health must be attended to and suitable games be prescribed. Floor lounging and the prone position should be encouraged. A sloped-back chair or a reclining board should be used. Exercises to strengthen the spinal muscles are of great service. These should be as simple as possible so that they can be done at home under the supervision of a parent or nurse. J. Porter Parkinson.

Tranquil tracheotomy by injecting cocaine within the windpipe (*'Brit. Med. Journ.,'* 1919, II, *p.* 460).—**StClair Thomson.**—This technical improvement for rendering tracheotomy quieter, simpler and safer has been employed by the author and his pupils for the last six years, so that the method has been well tested in scores of cases before being published in detail, which it is now for the first time. It is equally useful if the tracheotomy is performed under a general or a local anæsthesia. After trials with



a 5 per cent. solution of cocaine it has been found that a solution of $2\frac{1}{2}$ per cent. is as effective. It is used as follows: An ordinary hypodermic syringe is charged with about twenty drops of a $2\frac{1}{2}$ per cent. solution of cocaine. As soon as ever the tracheal rings are laid bare the syringe is grasped, as one does a pen, with the forefinger about 1 inch from the extremity of the needle, and with this the windpipe is sharply stabbed between two rings. The middle ring and little fingers are resting on the neck, and they prevent the point from penetrating more than $\frac{1}{4}$ to $\frac{1}{2}$ in. within the lumen of the trachea. The cocaine solution is injected into the cavity of the windpipe, some 5 to 15 drops, and the needle is sharply withdrawn. The liquid in the windpipe at once gives rise to a slight, stuffy cough. It causes no spasm or distress, and as it trickles down towards the region which endoscopists know to be the sensitive spot of this area, viz. the carina at the bifurcation of the trachea, this tickling cough soon ceases. If there is no great urgency

ten minutes should be allowed to elapse, the time being occupied by clearing the front of the trachea, checking all bleeding, preparing the tube and so forth. At the end of that time the incision can be made into the trachea, and the cannula introduced without pain, spasm, or even the slightest cough as quietly and as smoothly as the original incision through the skin. The calm with which this proceeding takes place is in striking contrast with the agitated and often bloody and dangerous operation of former days.

AUTHOR'S ABSTRACT. -

Reviews.

DISEASES OF CHILDREN. By JAMES BURNET, M.A., M.D., M.R.C.P.Edin. Edinburgh: E. & S. Livingstone, 1919. Second edition. Price 8s. 6d. net.

As an introduction to the study of disease in children this work is obviously appreciated, seeing that it has soon reached a second edition. It is particularly suitable for medical students who are taking up a special course of study in this subject, and for medical practitioners entering on general practice or wishing to have at hand a simple and practical work of the more common ailments of children. There is, perhaps, an unnecessary amount of verbiage; more conciseness would reduce the size of the book, and some of the elementary morbid anatomy could be omitted with advantage. In some respects it is not quite up to date. The value of serum in hæmorrhagic disease in the newborn is not mentioned, undue reliance being placed on adrenalin, and the advantages of Rammstedt's operation for pyloric hypertrophy are not considered. Probably many physicians would not endorse the value ascribed to digitalis and strychnia in the treatment of pneumonia and broncho-pneumonia, nor approve of the large doses of brandy recommended. Other minor criticisms might be advanced, but the author obviously has based his views on his practical experience, and deserves careful consideration. He has produced a sound and practical book, suitable for the audience he desires to address. E. C.

DISEASES OF THE EAR IN SCHOOL CHILDREN: AN ESSAY ON DEAFNESS. By JAS. KERR LOVE, M.D., F.R.F.P.S.G. Pp. viii + 94. Bristol: John Wright & Sons, Ltd., 1919. Price 5s. 6d. net.

DR. KERR LOVE'S incomparable little work comes at a very opportune time. It appears when the long-hoped-for Ministry of Health shows signs of a real materialisation, which, unless spoiled by the selfishness of vested interests and the obstructive apathy of those who wish to hold office without doing any work, should herald great reforms in the treatment of children in the pre-school as well as the school age.

Dr. Kerr Love has shown clearly how deafness can be prevented. And equal admiration must be expressed for the clear-sighted Glasgow officials who facilitated Dr. Kerr Love's work as for the work itself.

Although the book is a masterpiece of research into the causation of deafness; although it deals alike with the ravages of congenital syphilis

and the Mendelian aspects of hereditary deafness; although, in fact, it is a book to be read and re-read with increasing satisfaction and profit by both specialist and general practitioner, it is the remarks upon the treatment of suppurative middle-ear disease in children that perhaps most hold the reader, and are, at the present juncture, of the most importance. The discharging ear has been for a long time the *bête noir* of the hospital surgeon, the general practitioner, and the school doctor. Dr. Kerr Love shows how it should be treated, and how the right treatment, by skilled nurses under skilled specialist supervision, will subdue it. Without saying so in words, Dr. Kerr Love makes it plain that the ordinary practitioner does not know how to examine a discharging ear, and even less how to treat it. That is the reason why the treatment of otorrhœa in the London School treatment centres is so unsatisfactory. The classing of discharging ears with "minor ailments" is as ludicrous as it is inaccurate. These cases require to be treated by otologists in special aural clinics. The present way is a failure and a waste of money.

A standing committee has been formed by the Otological Section of the Royal Society of Medicine to deal with the question of the skilled examination and treatment of ear troubles in early life. Such a committee, emanating from so powerful a body as the Royal Society of Medicine, should be able so to influence the Ministry of Health as to obtain the necessary reforms, unless such influence comes too late. M. Y.

TUBERCLE: A MONTHLY JOURNAL DEVOTED TO ALL ASPECTS OF TUBERCULOSIS. No. 1, October, 1919. John Bale, Sons & Danielsson. Monthly, 2s. 6d. net; subscription, 25s. per annum.

WE welcome the appearance of the first number of this journal, which is published under the direction of an editorial board of four, representing various groups of workers. Each month it is to contain original articles, together with summaries of current pathological, clinical, and sociological work. The literature of tuberculosis will be critically reviewed, discussions of societies will be reported, a Parliamentary representative will keep readers in touch with current legislative proposals, letters from foreign correspondents will appear, and the correspondence columns of the journal will be open for free discussion. There should be plenty of room for a periodical thus setting out to co-operate with all the agencies engaged in fighting tuberculosis; in addition, the editorial board intend to put their services at the disposal of subscribers for the interchange of useful information, references, library facilities, and the like, so far as is practicable.

The first number leads off with an article on "Endo-pleural operations in Pulmonary Tuberculosis," by Dr. Holmboe, of the Mesnalien Sanatorium, in Norway. Dr. John Guy, of Edinburgh, writes on the "Necessity for a Uniform Standard of Classification in Pulmonary Tuberculosis." Many pages are given to book notices, abstracts from recent current literature, critical reviews, current topics, the activities of central and local authorities and societies, general news, and appointments. The first number of "Tubercle" is full of promise, and we wish the journal a successful career.

A. J. J.-B.

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